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Kathleen Murphy Adams
Iowa State University

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A critical discourse analysis of the response of AAMFT Approved Supervisors to a case vignette describing the perpetration of violence in a family

by

Kathleen Murphy Adams

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Kathleen Murphy Adams

has met the dissertation requirements of Iowa State University

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Major Professor

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For the Major Program

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For the Graduate College

It is at first terrifying,
and then exhilarating,
to disconnect our epistemologies
from the givens and authorities of our dominant cultures
... to attempt to center our authority within ourselves,
in terms that resonate to feminist understanding.

To do so, to persist...
is to make possible the vision...
in our theories of psychotherapy,
in the lives of our clients,
and ultimately
in the patriarchal societies that we struggle daily to transform.

That vision,
of the just society
in which oppression and domination are no longer
the norm,
is the image formed by theories of feminist therapy,
and ultimately
the future that lies before us.

Laura Brown, 1994

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ABSTRACT

Concerns about how family therapists respond to violence in families have been discussed in the literature for more than two decades (e.g., Bograd, 1984; Cook & Franz-Cook, 1984; Crnkovic, Del Campo, & Steiner, 2000; Goldner, 1985; Hansen, 1993; Harway, Hansen, & Cervantes, 1991, 1997; James & McIntyre, 1983; Pressman, 1989; Shamai, 1996,).

In the training of family therapists, the role of supervision is critical. This study was designed to determine to what extent clinical supervisors' awareness of violence in families reflects or contradicts the poor awareness of family therapists as reported in the literature. Feminist informed critical discourse analysis was used, with a particular emphasis on exploring how the language that supervisors used addressed agency for violence.

54 AAMFT Approved Supervisors provided written conceptualizations and interventions for a case vignette that described the severe perpetration of violence by a husband and father toward his wife and children or by a mother and wife toward her husband and children.

Data was evaluated qualitatively and quantitatively. Results indicated that the Approved Supervisors acknowledged the violence more than family therapists in past studies did when conceptualizing the case, but appear to have similarly poor awareness regarding appropriateness of intervention. Significant differences with regard to supervisor gender and perpetrator gender were found. Additionally, most participants

addressed the perpetration of the violence without assigning agency for it. For example, rather than stating "He is physically violent toward her and the children," participants used terms like "marital conflict," "family violence," or "difficulty with anger issues." The agency of the perpetrator remained obscured.

Recommendations for training family therapists and for further research are discussed.

INTRODUCTION

Statement of the Problem

The most violent social institution is the family (Gelles, 1997). The chief crime threatening the physical safety of women and children in the United States today is the perpetration of violence by a family member (Males, 1999). In fact, people are more likely to be victimized by violence perpetrated by a family member, in their own homes, than by anyone else, anywhere else in society (Gelles, 1997).

Women are at significantly greater risk than men. Twice as many women as men in one recent study reported that they had been raped and/or physically assaulted by a current or former intimate partner sometime in their lifetime (Tjaden, P., & Thoennes, N. 2000). "The phenomenon of violence against women in this society is as damaging to our national health as the wounds perpetrators inflict on their victims" (Smith Arnold & Sobieraj, 2000).

Violence toward a partner is a statistically significant predictor of violence toward children (Ross, 1996). The greater the amount of violence toward a partner, the greater the probability of violence toward a child by the physically aggressive partner. The probability that the perpetrator will also be violent toward the children increases in direct proportion to the number of violent acts perpetrated against the partner. This is more so for fathers than mothers. In a study of more than 3000 families (Ross, 1996), women who were the most chronically violent toward their partners had a 38% probability of also being violent to a male child, the gender most often physically abused. The most

chronically violent husbands, however, had nearly a 100% probability of also being violent to their male children.

Past surgeon generals of the United States, identifying the perpetration of violence in families as an epidemic, have formally called for organized approaches to its screening, treatment, and prevention (Poirier, 1997).

It was disturbing to me as a family therapist to learn that family therapists are not leading the response, but that in fact we have been criticized for some time about our expertise regarding violence in families. For the past 20 years scholars have been discussing concerns about how poorly therapists respond to violence in families 5 (e.g. James & McIntyre, 1983; Cook & Franz-Cook, 1984; Bograd, 1984; Goldner, 1985; Pressman, 1989; Harway, Hansen, & Cervantes, 1991; Hansen, 1993; Shamai, 1996; Harway, Hansen, & Cervantes, 1997; Crnkovic, Del Campo, & Steiner, 2000).

Poor therapist response appears to take two forms. A significant number of therapists do not recognize violence in families when presented with it (Aldarondo & Strauss 1994; Holtzworth, Munroe et al, 1992), and when violence is recognized a significant number of therapists intervene without respect for power differentials (Shamai, 1996).

Within the field of Marriage and Family Therapy, Approved Supervisors (AS's) are responsible for evaluating the competencies of family therapists. Yet research on AS's is minimal (Todd & Storm, 1997), and there is no empirical evidence regarding the expertise of supervisors themselves in this area.

Study Goals

Two goals drove this study. The first was to develop a working hypothesis regarding the extent to which the awareness of AAMFT Approved Supervisors reflects and/or contradicts the reports in the literature regarding the poor awareness of violence in families of Marriage and Family Therapists. The second was to encourage discussion, and to increase Approved Supervisors' awareness of the very serious problem that the field has in poor response to violence in families.

Study Design

"The naturalist does not attempt to form generalizations that will hold in all times and in all places, but to form working hypotheses that may be transferred from one context to another depending upon the degree of 'fit' between the contexts" (Guba, 1992). This is a qualitative study. While some quantitative procedures were used to describe some of the results, in design it is a qualitative study designed to meet the above goals

Discourse and Definitions

The primary research method used in this study is critical discourse analysis. Discourse analysis is a relatively new qualitative method of inquiry that seeks to illuminate how a particular phenomenon is constituted through written and verbal practices. Particular emphasis is placed on identifying the social consequences of those practices. Discourse is the medium that provides the ideas and words for thought and speech, as well as for cultural practices (Hare-Mustin, 1994). Foreclosure, meaning to

shut out completely, to exclude (Butler, 1997), is the result of that part of the dominant discourse that functions to censor, repress or obscure particular cultural realities and practices. With this awareness, the following terms and understandings are used:

Violence: Any act that is performed with the intention of causing physical harm, pain, or trauma. Violence can be physical, sexual and/or emotional.

Trauma: Physical, emotional, intellectual or spiritual wounding

Violence in families: Violence that is directed at an intimate or family member. This language is preferable to "family violence", "domestic violence", or "intimate violence" because the latter imply that the violence is without personal agency and is systemic in its origin and perpetuation.

Therapist, family therapist, family and couples therapist, couples therapist: Marriage and Family Therapists (MFT's) who are clinical members of the American Association of Marriage and Family Therapy (AAMFT). Use of the term "marriage" effectively obscures the reality of heterosexual partners who are not married, as well as the reality of lesbian and gay partners.

REVIEW OF THE LITERATURE

Poor Therapist Response to Violence in Families

Family therapists themselves have expressed concern regarding their own preparedness to work with violence in families. Results of a survey questionnaire, administered to 205 graduates from degree-granting Marriage and Family Therapy training programs accredited by the American Association of Marriage and Family Therapists (AAMFT) Commission on Accreditation for Education (COAMFT) indicated that graduates strongly recommended increased training in violence in families issues (Max, 1996).

Arguments that support lack of therapist preparation can also be found in the work of Harway (1992) and Goodwin (1993). Both state that family and couples therapists are not sufficiently prepared to work with violence in families and recommend that training specific to violence in families issues and interventions be included in all graduate training programs.

Additionally, family therapists are aware of only a small proportion of the cases of violence in families in their practices. More than two-thirds of clients in family therapy clinics engage in some form of physical violence against their partners within the year prior to the initiation of therapy (Straus, 1994). Yet most therapists report that violence is not a significant problem in their practice (Aldarondo & Strauss, 1994).

Further support of poor therapist awareness is found in a study by Holtzworth-Munroe et al (1992). They reported the very disturbing results of their attempts to recruit nonviolent men as control subjects for research on marital violence. They asked

clinicians to provide them with referrals for five different studies. By self-report of those referred, they learned that 55-56% of the men in these reportedly non-violent couples had been violent toward their wives. Their acts of aggression were varied, but most had engaged in several different violent behaviors, including choking and use of a knife or a gun.

In a 2000 study (Crnkovic, Del Campo, & Steiner), perceptions of 92 mental health professionals regarding violence in families were explored. They were presented with the questions on the Family Environment Scale and asked to answer them as they thought women living in homes where they and their children were physically and/or psychologically abused would respond. Their scores were compared to those of 28 mothers in battered women's shelters. They differed significantly in their perceptions of family dynamics with regard to levels of cohesion, expressiveness, independence, intellectual-cultural orientation, active-recreational emphasis, and moral-religious emphasis. They believed the women to have lower levels on these constructs than the women actually reported. The authors recommend that mental health professionals become more aware of the dynamics of violence in families in order to efficiently identify the violence and provide appropriate services.

The results of another study that surveyed members of AAMFT is consistent with the reports in the Crnkovic, Del Campo, and Steiner and the Holtzworth-Munroe et al, study. Harway, Hansen and Cervantes (1991, 1997) asked their study participants (more than 300 family and couple's therapists, and pyschologists) to conceptualize and provide interventions for an actual case involving severe violence in a family. The vignette used,

taken from court records in which the husband was later convicted of manslaughter for killing his wife, clearly stated that the husband/father had been repeatedly violent toward the children as well as to his wife.

Forty percent of the MFT's in their 1991 study did not acknowledge the violence in their responses to the vignette. Only 45% reported that they would intervene as if the situation merited immediate action, and only 11% addressed the need to establish safety. Twelve percent addressed reporting the abuse, though it was not clear to whom, nor whether it was child or partner abuse that would be reported.

Hansen, Harway, and Cervantes did not initially choose the vignette to elicit responses about violence in families. Rather, it was part of a study designed to examine therapist attitudes about the concept of "co-dependency." Hansen, Harway and Cervantes chose the case scenario because they believed that it described a case of obvious and extreme violence in families. Respondents were expected to recognize the violence and to emphasize the shared responsibility for the family conflict presented to them. Of the 60% who did focus on the violence, 91% of those considered the violence mild to moderate. Only 5% of total respondents addressed the violence and considered it severe. The interventions that were recommended frequently failed to address the crisis nature of the violence, or the need for protection for the wife and children.

A 1999 study on the training that mental health professionals receive regarding violence against women reported that 59% of a sample of 415 licensed Illinois mental health professionals had received training on violence in families. That training took place in continuing education courses, not in their graduate training programs (Campbell,

Raja & Grining, 1999). While this research did not specifically study family and couples therapists, it is interesting to note that the 59% training rate is nearly identical to the 60% rate of violence identification in the Harway, Hansen and Cervantes (1991, 1997) studies.

The expanse of the Hansen, Harway and Cervantes study did not include exploration of the issues of mandated reporting or protection for the children. Children who witness partner violence in their home have more behavior problems and are more likely to imitate aggressive behavior than are children from nonviolent homes; and adults who are violent toward their adult partners are also likely to abuse their children (Moffitt 1998). Violence in families is the slap that is felt for generations (Mathias, 1986).

Concern about the response of mental health care professionals to violence in families first appeared in the literature a quarter of a century ago (Martin, 1976). Since that time, feminist therapists and scholars, activists who have been working directly with the survivors of violence in families, and family sociologists, have been discussing the issue in the literature (James & McIntyre, 1983; Bograd, 1984; Goldner, 1985; Taggart, 1985; Avis, 1988; Gelles & Straus, 1989; Willback, 1989; Pressman, 1989; Aldarondo & Strauss, 1994). In fact, the Journal of Marital and Family Therapy devoted the better part of an issue specifically to discussion of MFT response (Volume 18, 1992). The contention was that the field of family therapy was at best ineffective in working with violence in families, and was at worst contributing to the problem. It is a contention that remains strong among many today.

Appropriate Therapeutic Response

Appropriate assessment and intervention should begin with individual, not couple or family therapy (Bograd, 1984; Walker, 1994). Couple or family therapy implies that the victim is equally responsible for the violence. It can place the victim in danger of more violence if the perpetrator interprets that the therapeutic situation provides justification for his violence. Additionally, the perpetrator may attempt to control what the victim discusses in therapy by becoming more violent.

Ethical, professional, legal and practical priorities demand that assessment first focus on determining the level of danger. This includes the possibility that the perpetrator's violence could escalate to lethality (Straus, 1996). Assessment of danger involves evaluation of the following: (a) history of repeated violence, including forced sexual acts; (b) threats or fantasies of killing or suicide; (c) availability of weapons, use of weapon, or threats to use a weapon; (d) extreme possessiveness/jealousy placing the partner at the center of the perpetrator's life, accompanied by attempts to control the partner's movements; (e) threats of violence at time of separation or loss (f) risk-taking behavior with minimal or no concern for personal, social, and legal consequences: (g) severe depression and/or other psychological concerns: (h) repeated use of alcohol and/or other chemicals; (i) presently abusing a child/children and a history of having been abused as a child: (j) violence toward animals: and (k) severe and repeated destruction of property (Campbell, 1995 as noted in Eisikovits & Buchbinder, 2000). Level of danger is determined based on the degree to which each of these risk factors exists.

Once level of danger is established, intervention focuses on warning and protection. Warning involves making sure the victim is fully aware of the risks of violence, and may involve helping the victim recognize those risks.

The development of a safety plan is critical for protection. An acceptable safety plan includes (a) review of the perpetrator's patterns in order to help the victim recognize future cues of violence; (b) creating an "escape route" for quick departure from potentially dangerous situations; (c) preparing support systems and calling for help or protection; and (d) becoming familiar with sources of support within the larger community (Gondolf, 1998 as noted in Eisikovits & Buchbinder, 2000.)

"Protection also means that practitioners who are aware of immediate danger should call the police and help prepare a secure environment for the woman, such as a shelter or a safe home" (Eisikovits & Buchbinder, 2000 p. 159).

Additionally, if the perpetrator's violence is directed toward children, the therapist is legally bound to report that to the appropriate local government social service agency. MFT's are mandated by law, in all 50 states, to report child abuse. In Iowa the report is to be made to the Department of Human Services.

In the training of MFT's, Approved Supervisors are responsible for ensuring that MFT's responds appropriately, as outlined above, to families where violence is being perpetrated.

The Role of the AAMFT Approved Supervisor

Approved Supervisors are responsible for protecting client welfare, rights, and best interests, and are accountable for ensuring that clients receive informed, appropriate care (Mead, 1990).

Similar to training programs for physicians, all professional mental health disciplines require that their trainees participate in a two tiered preparation program, academic coursework followed by rigorously supervised clinical practice. The clinical practice requirements can be compared to the residency requirements of physician trainees and involve thousands of hours of clinical practice under the supervision of advanced clinicians.

In the training of AAMFT credentialed Marriage and Family Therapists, the responsibility for supervising the clinical practice experience falls to MFT's who have completed the AAMFT credentialing requirements for Approved Supervisor status. (Appendix A.) Many, but not all, faculty in graduate MFT training programs are AAMFT Approved Supervisors. For AAMFT credentialing, the MFT course work does not have to provided by an Approved Supervisor. The supervision of clinical practicum must be provided by an Approved Supervisor.

In the first chapter of their widely used text, The Complete Systemic Supervisor, Todd and Storm (1997) cite the work of Engleberg and Storm (1990) and Slovenko (1980) in stating that AS's are considered the qualified service providers, legally liable for the work of their supervisees. The supervised practicum is presented to consumers as a way to receive clinical services from partially trained, yet fully supervised

professionals who require opportunities to practice to become qualified.

Generally, the AS and the therapist trainee develop a relationship that continues over a contracted period of time. The supervision focuses on the therapist's practice setting and more specifically on the therapist's development of competency (Liddle & Saba, 1986). AS's follow therapists' cases closely. The hallmark of supervision in MFT is this focused attention on specific cases (Piercy & Sprenkle, 1986).

AS's ultimately protect the reputation of the profession of MFT and ensure public confidence in the profession. They ensure that therapist trainees are adequately prepared and have the professional competency to provide quality care to consumers (Storm, 1991). In fact, most believe that through their evaluation of their supervisees' competence they serve as gatekeepers for their profession (Mead, 1990).

In reviewing the literature discussing issues of gender and power in family therapy, Turner and Fine (1997) note the emergence of three themes with regard to clinical supervision: (a) empowerment of women; (b) androgyny and professional skill development; (c) postmodernity and inclusivity.

With regard to the empowerment of women, Turner and Fine (1997) note that a number of authors maintain that women therapists and supervisors are disadvantaged and need to be empowered (e.g. Avis, 1989, Okun, 1983). These scholars suggest that supervisors work toward increasing general knowledge about women and power inequities; ensure that women therapists are safe and appropriately treated in supervision with male supervisors; and help female supervisors confront those male therapists who may not respect the authority and expertise of a woman.

It was further proposed that female therapists be supervised by supervisors who are healthy and competent female models – expert mentors empowering female therapists who will, in turn, empower their female clients.

The literature addressing the theme of androgyny and professional skill development focuses on discussion of androgyny as the goal for both sexes. The roots of this approach can be found in the 1980's belief that strong executive skills and assertiveness – traditionally male attributes – were essential for competency as a therapist within the strategic models of the time. Women, socialized to be submissive and approval seeking, were often seen as lacking competence (Turner & Fine, 1997).

Critical of this approach, Turner and Fine (1997) state "The proposal for androgeny is narrow in its focus on making changes in gendered behavior as individuals. It does not directly challenge the multitude of ways in which the larger social system supports, and is supported by, patriarchal ideologies and practices" (p. 75).

Postmodern influences questioning the certainty of relationships, personal identity and political alliances have led to confusion and controversy about gender and power issues. Focuses on female and male, power and disempowerment are without reference points in postmodern epistemologies. Rather there is an emphasis on self-awareness and the development of collaborative therapist-client and therapist-supervisor relationships. Supervision moves to explorations of gender self-descriptions, expectations for others and the complexity of power differentials concerning multiple self-identities related to race, class, sexual identity, religion, etc. Supervisors are encouraged to consider the simultaneous intersection of gender with these other relationship organizing principles.

In the one article in the literature specific to supervision and violence in families, Goodwin (1993) recommends a culturally sensitive feminist model of supervision. She states "...it is difficult to find in the violence in families literature a discussion of how supervision prepares supervisors or therapists to recognize and provide clinical services to victims and/or perpetrators of family violence. Clearly, considering the role of supervision in the preparation of supervisors and clinicians is an especially timely, yet neglected topic area" (p. 120).

Given the strong emphasis on clinical supervision in family and couple's therapy, it is very surprising that there is little empirical research on supervision. Todd and Storm (1997) candidly state "The research literature on. . . supervisory effectiveness is so scant that the training of supervisors is primarily based on our cherished beliefs, sometimes on historical accidents, and frequently on the pragmatics of the context in which supervision occurs" (p. 14).

There does not appear to be any research focusing on the basic clinical competencies of the supervisor (i.e. awareness of gender and socio-cultural issues and power differentials) or how that competency impacts the trainee's professional development. It seems the field assumes that the rigorous training and supervision that clinical supervisors receive ensures that all Approved Clinical Supervisors have basic clinical competencies. This assumption has no empirical support. Research providing empirical support is clearly needed.

A Sociological Construction of the Problem

There are family violence scholars who maintain that therapy is ineffective because the violence isn't recognized, and there are feminist scholars who maintain that therapy is ineffective or damaging, because of poor intervention. There are, of course, scholars who share both concerns.

Murray Straus, Professor of Sociology and Director of the Family Research Laboratory at the University of New Hampshire, is perhaps the most widely recognized sociologist specializing in research on violence in families. He co-authored an article (Aldarondo & Straus, 1996) specifically discussing the issue of poor therapist response to violence in families. While acknowledging the academic discussion about therapist intervention, his article focused on recognition, on the fact that therapists recognize only a small proportion of their clients who are victims of physical assault. A number of reasons for this are proposed and categorized as either client-based or therapist-based.

Seven reasons, which have their "locus in clients", are discussed:

Perception of physical violence as trivial or tolerable: For some clients occasional instances of violent behavior are not considered important enough to bring up in therapy.

Violence as a form of conflict resolution: The use of physical force to resolve family conflicts may be the multigenerational norm for some clients. Consequently it is unlikely that they will raise the issue in therapy.

Narrow focus: Some clients may feel that the violence is unrelated to the reason that they sought therapy. They narrowly focus on the "real problem" and do not talk about the violence.

Making a good impression: Some clients may minimize or deny the occurrence of violence to present and maintain a positive image of themselves in therapy.

Shame and humiliation: Some clients may choose to conceal the violence to protect themselves or their loved ones from public condemnation or humiliation.

Fear and perceived risk of victimization: Some clients fail to disclose violence because they do not trust the therapist. They fear that their partner may learn about the disclosure and that they or the children will be hurt further. Others may fail to discuss the violence because they believe that the perpetrator will soon "come to his senses" and bring the violence to an end.

Love and concern for partner: Some clients may not disclose the violence because they fear the possible retributions for the perpetrator and they fear being separated from him.

This fear is a concern of particular significance to women of color. "Most battered women of color are acutely aware of how the police routinely brutalize men of color, how hospitals and social services discriminate against men of color and the ways men of color are more readily labeled deviant than white men. . . .For battered women of color, seeking help for the abuse they are experiencing always requires a tenuous balance between care for and loyalty to themselves, their batterers, and their communities" (Ritchie & Kanuha, 1993, pp. 291-292).

Aldarondo and Strauss continue to discuss three reasons connected to the characteristic of therapy and therapists that contribute to lack of recognition of violence.

Not asking: Some of the reasons effecting client disclosure also apply to therapists. Therapists may not ask about violence if they tend to trivialize it, perceive it as a valid form of conflict resolution or prefer to maintain a narrow focus on the client's presenting issue.

Additionally, therapists may experience themselves as neutral participants and may choose not to raise issues of violence, fearing they will be experienced as challenging, intrusive or biased. Some therapists may not ask about violence in the family because they fear it will preclude a prompt resolution of the client's presenting concerns.

Who is asked and in what context: Family therapists have difficulty recognizing violence in traditional couple therapy interviews (Cook & Frantz-Cook, 1984). Aldarondo and Straus note that men in treatment for violence, and men in couples therapy, minimize their violence. Both partners must be asked, and asked separately.

Inappropriate language: Therapists who use terms like "violence" may not elicit valid responses when asking about violence in families. The rhetoric of clients may vary greatly from that of the therapist. The client may name an experience of violence as a "push" or a "shove" but not "violence."

Language, and the discourse that frames it, are also concerns for feminist scholars.

A Feminist Construction of the Problem

In the early 1990's, feminist theory was becoming the dominant model for explaining violence against women (Gelles, 1993). It is not surprising then that feminist scholars have written at length about poor therapist response. Generally, they express concern that therapists are contributing to the problem of violence in families through intervention that disregards the power differentials in relationships.

In a succinct review of the feminist literature, Shamai (1996) reviews six possible reasons for poor therapist intervention. First is the concern that family therapy has ignored the context of the larger socio-political system within which violence in families occurs, and has focused solely on the system of the family itself. General systems theory (GST) views families as complex self-reflexive cybernetic systems that must be understood as wholes rather than as the sums of their component parts.

Feminists note the paradox inherent when this micro-systemic perspective ignores the reality that the family is itself a component of larger social systems and is strongly influenced by those systems. Used in this non-contextual way, GST assigns men and women equal power and equal responsibility for maintaining family patterns, independent of cultural realities.

The following poem, Maya Angelou's (1994) powerful and provocative work, "Coleridge Jackson" serves well to illuminate these concerns.

Coleridge Jackson

Coleridge Jackson
had nothing to fear.
He weighed sixty pounds
more than his sons and one
hundred pounds more than his wife.
His neighbors knew he wouldn't
take tea for the fever.
The gents at the poolroom
walked gently in his presence.

So everyone used to wonder why,
when his puny boss, a little
white bag of bones and
squinty eyes, when he frowned
at Coleridge, sneered at
the way Coleridge shifted
a ton of canned goods from
the east wall of the warehouse
all the way to the west,
when that skimpy of piece of
man-meat called Coleridge
a sorry nigger,

Coleridge kept his lips closed,
sealed, jammed tight.
Wouldn't raise his eyes,
held his head at a slant,
looking way off somewhere else.
Everybody in the neighborhood wondered
why Coleridge would come home,
pull off his jacket, take off
his shoes, and beat the
water and the will out of his puny
little family.
Everybody, even Coleridge, wondered
(the next day, or even later that
same night).

Everybody. But the weasly little
sack-of-bones boss with his
envious little eyes,
he knew. He always
knew. And
when people told him about
Coleridges's family, about the
black eyes and the bruised
faces, the broken bones,
Lord, how that scrawny man
grinned.

And the next
day, for a few hours, he treated
Coleridge nice. Like Coleridge
had just done him the biggest
old favor. Then, right
after lunch, he'd start on
Coleridge again.
"Here Sambo, come here.
Can't you move any faster
than that? Who on earth
needs a lazy nigger?"

Coleridge Jackson, in misdirecting appropriate rage, has become an agent of racial hatred and violence for his boss. This is a situation that would demand that the therapist have an acute understanding of how the family is influenced by larger social forces.

There can be danger, however, in pursuing an understanding of the greater social context. Therapists must take care to make sure it does not lead to a minimization of the perpetrator's responsibility for the violence.

In the following poem, Pat Parker (1983) speaks to this concern.

Brother,
I don't want to hear
about
how my real enemy
is the system.
i'm no genius,

but i do know
that system
you hit me with
is called
a fist.

The next concern that Shamai addresses is that the predominant GST model of family therapy views particular behaviors of one part of a family system as being determined and maintained by other parts of the family system. As noted previously, from this perspective responsibility for violence is shared. This perspective also easily leads to blaming the victim for the the violence. Minuchin (1984) illustrated this thinking when he stated that it was necessary to remove the violence from a family member, and locate it in the interactions among family members, before it can be defused.

It is at the very least ironic that the field of Marriage and Family Therapy, with a history of eminent therapists who have rarely incorporated feminist principles in their therapy (Haddock, 1995), is faulted for an emphasis on gender equality.

The third criticism Shamai focuses on is the phenomenon of therapist neutrality, a concept that has traditionally been strongly emphasized in traditional GST family therapy training. This area of concern notes that neutrality negates the therapist's ability to focus on the perpetrator's responsibility for the violence. Without a focus on the agent of the violence, effective intervention is impossible. The status quo is maintained.

When the status quo is maintained, the victims remain silenced. Herman, in her 1992 hallmark book, Trauma and Recovery explains this phenomenon:

... when the traumatic events are of human design, those who bear witness are caught in the conflict between victim and perpetrator. It is morally impossible to remain

neutral in this conflict. The bystander is forced to take sides. It is very tempting to take the side of the perpetrator. All the perpetrator asks is that the bystander do nothing. He appeals to the universal desire to see, hear, and speak no evil. The victim, on the contrary, asks the bystander to share the burden of pain. The victim demands action, engagement and remembering... The study of psychological trauma must constantly contend with this tendency to discredit the victim or to render her invisible (p. 7).

Consider for a moment this same paragraph with the substitution of the word "therapist" for the words that have been stricken below:

... when the traumatic events are of human design, ~~those who bear witness~~ therapists are caught in the conflict between victim and perpetrator. It is morally impossible to remain neutral in this conflict. The ~~bystander~~ therapist is forced to take sides. It is very tempting to take the side of the perpetrator. All the perpetrator asks is that the ~~bystander~~ therapist do nothing. He appeals to the universal desire to see, hear, and speak no evil. The victim, on the contrary, asks the ~~bystander~~ therapist to share the burden of pain. The victim demands action, engagement and remembering... ~~The study of psychological trauma~~ Therapists must constantly contend with this tendency to discredit the victim or to render her invisible.

There is no neutral therapeutic stance. "Neutrality" reflects therapeutic ignorance of power differentials and is experienced as alliance with the perpetrator. Therapist neutrality is de facto support for the perpetration of violence in families.

The fourth issue Shamai cites regards the controversy about whether violence is

perceived as a symptom of other family problems. The perception that the violence serves a particular function, or functions, in the family leads therapists to ignore the violence in favor of exploring its function.

Assessment procedures that lead to minimization of abuse are the basis for the fifth concern Shamai addresses. Two points are key in understanding this concern. The first is that family therapy has tended to maintain the family's power differential in the therapeutic situation (Cook 1984). The second is that given the power imbalance and the realistic fear of retributional violence, the abused partner is likely to agree with the perpetrator's minimization of the violence.

Jane Smiley's novel, A Thousand Acres (1992), illustrates how the violence is minimized when the perpetrator's perspective is privileged. Smiley accomplished the monumental task of writing a contemporary revision of Shakespeare's King Lear set on an Iowa hog farm. Her narrator, the adult daughter of an abusive father, has succumbed completely to the power differential inherent when there is violence in families. While she tells the story in the first person of her own voice, it is her father's story she tells throughout the novel. In the following passage, she makes an effort to raise her own voice. The narrative stance is actually that of her father, the perpetrator. Consequently the violence is minimized (Daly, 1998).

He drank from his coffee. "You shouldn't talk to me like you do. I'm your father."

"I try to show respect, Daddy."

"You don't try hard enough... you don't ... make up to me any more. I know what's going on."

"That's not true, Daddy..." I smiled. "You're not the easiest person to get along with, you know."

"I don't like it when people are lazy, or when they don't pay attention. This is a hard business, and takes hard work."

I continued to smile... "I don't think you can say that we're lazy. Anyway, I don't think you show us any respect, Daddy. I don't think you ever think about anything from our point of view."

"You don't, huh? I bust my butt working all my life and I make a good place for you and your husband to live on, with a nice house and good income, hard times or good times, and you think I should be stopping all the time and wondering about your, what did you call it, your 'point of view'?"

I felt myself redden to the hairline... "I just want to get along, Daddy. I don't want to fight. Don't fight with me?"

"You know, my girl, I never talked to my father like this. It wasn't up to me to judge him, or criticize his ways. Let me tell you a story about those old days, and maybe you'll be reminded what you have to be grateful for."

"Okay." I was smiling like a maniac.

"There was a family that had a farm south of us. The old man was older than my dad, and he'd come in and drained that land down there, him and his sons. He had four sons, and when the youngest was about twelve, he came down with that polio thing. This was a long time ago, before I even went to school. Well, that boy was all crippled up by the time I remember him, but he didn't stay in the house,

nosiree. The old man got him out there and made him plow his furrows as straight as the other boys, and he whipped him, too, to show him that there wasn't any way out of it. There were a couple of daughters, and one up and left home when she was about sixteen, calling her father all kinds of a bully and slave driver, but the thing is, that boy did his share, and he respected himself for it. It was the old man's job to see to that."

"How do you know?"

"What?"

"How do you know he respected himself for it, that that was what he needed?"

"I saw it!" He was beginning to huff and puff.

I said, "Okay, Daddy. Okay. I don't want you to be mad..."

"You girls should listen to me."

"We'll try harder, Daddy."

It was easy, sitting there and looking at him to see it his way. What did we deserve, after all? There he stood, the living source of it all, of us all. I squirmed, remembering my ungrateful thoughts, the deliciousness I had felt putting him in his place. When he talked, he had this effect on me. Of course it was silly to talk about "my point of view." When my father asserted his point of view, mine vanished. Not even I could remember it.

"When my father asserted his point of view, mine vanished. Not even I could remember it." What powerful testimony that is to what victims and survivors of violence in families experience when therapists privilege the voice of the perpetrator.

Lastly, Shamai discusses concerns about how therapists enter the family system. She cites Hansen and Goldenberg's (1993) study that noted that therapists often enter family systems through the victim because they are more likely to be receptive to therapy than the perpetrator. Aligning with the victim may minimize the focus on the perpetrator and imply that the victim is equally responsible for the violence. Alternately, therapists might enter the system by joining with the perpetrator. Clearly this perpetuates the power differential and leads to a mistaken understanding of what is actually happening in the family.

Are we to conclude that feminist theory and family systems thinking are mutually exclusive? No. In fact, the incorporation of feminist principles into family therapy enhances the possibilities of working effectively with intimate violence. Appropriate contextual use of systemic thinking incorporates concepts of gender roles and biases, power differentials, hierarchies, intergenerational patterns, and the influences of larger social systems (Cook & Frantz-Cook, 1984; Goldner, 1985; Hansen & Goldenberg, 1993; Shamai, 1996). Safety plans for the vulnerable can be prioritized and the perpetrators of violence can be held accountable. It is the assumption of equality of power, of indifference to the power differentials in relationships that allows for therapist neutrality and victim blaming.

I suggest that the roots of the six criticisms that Shamai discusses are all grounded in "marriage between equals" discourse that can only be perpetuated if therapists are indifferent to power differentials. It is this indifference that allows for the traditional use of GST family therapy theory that isolates the family from larger socio-

cultural realities. It is this indifference that allows for traditional use of GST therapy that leads to victim blaming through assumptions of shared responsibility for the violence. And it is this indifference that allows for the illusion of therapeutic neutrality that renders the therapist impotent in the face of the violence.

In their 1997 study of therapist response to violence in families, Harway, Hansen and Cervantes describe two major themes that surfaced in the responses of study participants who did not focus on the need to immediately establish safety: "Therapists who focused on the dynamics of the case...without recognition of the urgent context of the case," and "therapists who were hesitant to make any decision..." The latter of these two themes is consistent with the discussion of neutrality. I propose that the former theme, that of therapists who focused on the dynamics of the case, might have included responses reflective of non-contextual family systems thinking, and assumptions of gender and power symmetry, had the data been reviewed with those issues in mind.

The Gender Symmetry Debate

The literature on violence in families has been the arena for debates about gender, power and the nature of violence for twenty to thirty years. The debates had their beginnings when the first National Violence in families Survey (NFVS) was published in the late 1970s. Steinmetz (1977) wrote a now infamous paper on "husband-battering," using the NFVS data to support her thesis that husband-battering was as critical a social concern as wife-battering. In fact, the data gathered in the NFVS did show almost perfect gender-symmetry of violence toward partners. Feminist scholars rebutted, attacked the

validity of the NFVS data, and argued that all previous studies had found that violence in families was almost entirely male on female.

Feminists argue that family violence researchers disregard the influence of gender on relationships and see power in the family as a gender-neutral phenomenon. They see these gender-neutral assumptions about power in couples as part of the dominant, and false, "marriage-between-equals" cultural discourse. Women, with the primary responsibilities of child rearing and household work do not have the same power as men (Kurz, 1993). Additionally, research with the Conflict Tactics Scale, an assessment tool often used by family violence researchers, revealed that women saw more behaviors as abusive than are typically identified by the scale (Wagner & Mongan, 1998).

Family violence researchers maintain that they are not indifferent to power differentials, and that male dominance and its "pernicious effects, including violence against women" (Straus, 1993, p. 81) are a central research focus. They note that violence by males results in more injury than does violence by females. Appropriately noting male agency, Straus continues with the "first priority in services for victims and in prevention and control must continue to be directed toward assaults by husbands" (Straus, 1993 p. 81).

Family violence researchers are concerned that feminists focus on the power and control issue as the single causal factor of violence in families, and that this unitary focus limits full understanding of the phenomenon (Straus, 1993).

Feminists respond with questions. Why, if violence between intimates is truly recognized as a gendered phenomenon, are sociologists not seeking explanations for this

phenomenon? "The proposition that some sectors of society are more violent than others, especially when they have rules that legitimate or even require violence, would seem a useful start toward the analysis of male violence" (Yllo, 1993). Recent findings from the National Violence Against Women Survey, sponsored by the Center for Disease Control and the U.S. Justice Department, support Bureau of Justice Statistics National Crime Victimization Survey data which consistently show that women are at significantly greater risk of being assaulted by an intimate partner than are men (Tjaden & Thoennes, 2000). They contradict data from the National Family Violence Survey, which consistently show men and women are equally likely to be physically assaulted by an intimate partner. Recommendations were made that further study be done to determine how different survey methodologies affect women's and men's responses to questions about intimate partner violence.

Published concurrent to the Tjaden and Thoennes paper (2000), Johnson & Ferraro (2000) presented their research and conclusions about survey methodologies and the gender symmetry controversy. While somewhat limiting in their dualism, their ideas deserve attention.

They note that those on one side of the debate are the family violence researchers. The designers of the NFVS, Straus and Gelles, are members of this group. These scholars are generally sociologists comfortable with large-scale survey research methods. They assess violence in families with a set of survey questions called the Conflict Tactics Scales. Generally it is members of this group that argue that men and women are equally violent in intimate relationships.

On the other side of the issue are those generally referred to as the feminist researchers, with Dobash and Dobash (1998) being among the best known of them. Qualitative research is the preferred methodology, focusing on women who are clients of social welfare agencies such as shelters, courts, and hospitals. This group argues that violence against partners is male against female, and essentially about power and control. For these scholars, violence is a tool used by men to maintain the position of power that they have over women in patriarchal societies.

Johnson notes that using general survey samples, family violence researchers find gender-symmetric violence; and that feminist researchers using public agency samples find male violence against women. Each side in the debate challenges the others' research method complaining of bias. The debate seems without end.

In 1995 Johnson published a paper in which he argued that the research methods of each provided access to different, "virtually non-overlapping populations of violent couples, that there are two quite different types of partner violence, one gender-symmetric, the other decidedly, if not entirely, male." Johnson's contention is consistent with what Straus first stated in 1993, that discrepancies in the data reflect different groups of people and different aspects of violence in families.

Recently, Johnson published the results of a study that expanded further on his ideas (Johnson & Ferraro, 2000). He maintains that there are four distinct types of partner violence, each particular to the patterns of power and control exercised across time in the relationship. These four patterns are "common couple violence", "violent resistance","mutual violent control", and "intimate terrorism". The NFVS data

illuminated "common couple violence." The shelter and public agency data illuminated "intimate terrorism." The key to understanding the uniqueness of each of these four types of partner violence lies in the role that control plays in each type."

According to Johnson's research (1999), common couple violence is not rooted in any general pattern of control. It occurs in the context of a specific disagreement in which one or both of the partners lash out at the other. It is likely to be mutual, is gender symmetric, and is not as likely as intimate terrorism is to involve severe violence escalating over time.

In her 1936 short story, "Pre-Freudian", Canfield writes of a couple who "at home and abroad . . . fought openly and without shame, like cat and dog. . . . Will had the most hateful temper in the word, and seemed to enjoy nothing in life but to humiliate her - or try to! Other people said that his young wife gave him as good as he sent. . . . To a cold sneer from him, she responded with quick, fearless fury; when he made a scene she instantly made a worse one; if in a rage he deliberately broke or injured something she prized, she flew like a wild-cat to pour ink on his best shirt, or cut holes in his finest boots" (Canfield, p.125).

While Canfield's example suggests mutuality, in 31% of the Johnson study relationships involving mutual common couple violence the male partners were more frequently violent than the female partners. And 8% of the wives were more frequently violent. It is worth noting, however, that it is well established in the literature that male-to-female violence results in more serious injury than female-to-male violence (Straus, 1993).

Almost entirely, women perpetrate violent resistance, commonly referred to as self-defense. Johnson notes that research on the general dynamics of violent resistance is lacking, but that it appears to be in response to the controlling efforts of intimate terrorism. A piece from another short story (Trambley, 1993; in Koppleman, S. Ed.) illustrates: "There had come the day when she could no longer take his blows. After beating her, he had fallen asleep in a drunken stupor. Beatriz had taken the small, sharp ax she used to cut vines and jumped on the bed, straddling his bloated belly. She grabbed him by the hair and beat his head against the headboard until he came to his senses, bleary and stinking of panic. Full of hate, holding the ax high over his head, she had threatened, 'If you ever lay a hand on me again, I'll split your head.' Gulping in his astonishment and fright, Robles looked into the eyes of a woman who would not hesitate to kill. She hissed menacingly, 'I can do it while you're asleep - any time.'" (pp. 243, 244)

Koppleman, the editor of the book of short stories that these examples are taken from, notes in her acknowledgement section that a friend of hers once told her that "A man who sleeps with a woman he has beaten is a fool. His life is in danger" (1993, p.xxii).

Returning now to another of Johnson and Ferraro's categories of violence, mutual violent control is characterized by the involvement of both partners in patterns that are controlling and violent. It can be understood as two intimate terrorists fighting for control. Johnson states that this pattern is rare and that little is known about it.

Intimate terrorism, another category, is rooted in an overall pattern of control. It is

one tactic of many utilized most often by men to obtain and maintain control over a female partner. It is more likely than common couple violence to result in serious injury, it escalates over time, and is less likely than common couple violence to be mutual.

Nielson, in her autobiographical book Ice Bound (2001), tells of surviving the trauma of this type of violence: "Once when we were driving along a two-lane road with the children in the back seat, I told him that I wanted to see our checkbook. There was no money in the joint account and I wanted to know where it had gone. My husband pulled into the oncoming lane and stepped on the gas. I swear he would have kept going if I hadn't given in and told him I didn't need to see the checkbook. He drove into oncoming traffic another time with my parents in the car, I suppose just to show them that he could kill us all if he wanted to. . . .

Another time, he strangled the family dog right in front of me and our daughter, to teach us a lesson. He later told my mother how he'd watched the look of disbelief on the dog's face as he squeezed its throat. Then he shot it to finish it off.

After years of this treatment, I forgot how to fight him" (p.18).

Many situations are not this extreme, and yet some are lethal. Johnson and Ferraro note that the severity and variability of violence is considerable. Some common couple violence involves homicide and some intimate terrorism involves low levels of violence. Again, the key distinguishing feature is the presence or lack of a general motive to control. Intimate terrorism is characterized by a pattern of behaviors, both violent and non-violent, that indicate the general motive is to control the woman. Emotional abuse, demoralizing the woman, is common.

My own clinical work has offered me a window into each of the categories that Johnson and Ferraro describe, both in opposite sex and in same sex couples. I have heard the contention that violence in same sex couples, particularly lesbian couples, validates that violence is not a gendered phenomenon and that women are as violent as men. My experience has always run counter to that argument, and research data from the National Violence Against Women Survey now supports my experience (Tjaden & Thoennes, 2000).

Of the women surveyed who had lived with a woman as part of an intimate couple, slightly more than 11 percent reported being raped, physically assaulted, and/or stalked by a female cohabitant. In comparison, slightly more than 30 percent of the surveyed women who had married or lived with a man as part of a couple reported being raped, physically assaulted, and/or stalked by that man.

Additionally, men living with male intimate partners experienced more intimate partner violence than did men who lived with female intimate partners. 7.7 percent of men living with female partners reported violence by a wife or female cohabitant. 15 percent of the men who had lived with a male intimate partner reported violence by that partner.

As noted previously, women are as much as 10 times more likely than men to be injured "in acts of domestic violence" (Gelles, 1997, p. 93). The violence of men is clearly more common and more severe than the violence of women. Male violence must be the primary focus of research and intervention concern (Straus, 1993; Kurz, 1993).

Family Therapy and Discourse Theory

"Only a few decades ago, the term 'family violence' would have had no meaning..." (Brienes & Gordon, as noted in De Lauretis, 1989, p.240).

"...psychological problems seemingly appear, change shape, and disappear as therapists' vocabularies and descriptions change. The new challenge... is in examining therapists' descriptions... thus, redefining the problems they work with" (Anderson & Goolishian, 1988, p 375).

Collaborative language systems theory (CLS), one of the most recent epistemological shifts in family therapy theory, is characterized by its postmodern emphasis upon language (Anderson, 1997). CLS has six basic philosophical assumptions: (a) human systems are language and meaning generating systems (b) their construction of reality is forms of social action rather than independent individual mental processes (c) an individual mind is a social composition, and self, therefore, becomes a social, relational composition (d) the reality and meaning that we attribute to ourselves and others and to the experiences and events of our lives are interactional phenomena created and experienced by individuals in conversation and action (through language) with one another and with themselves (e) language is generative, gives order and meaning to our lives and our world, and functions as a form of social participation, and (f) knowledge is relational and is embodied and generated in language and our everyday practices (Anderson, 1997).

Discourse theory is based on similar assumptions. A postmodern approach to epistemology in general, discourse theory essentially explores how meaning is

constructed through systems of statements, practices and institutional structures that share common values and meanings (Best & Kellner, 1991). Discourse is the medium that provides the words and ideas for thought and speech, as well as for cultural practices (Hare-Mustin, 1994).

As part of the institutionalized mental health care system, family and couples therapy uses, and consequently reinforces, dominant cultural discourses (Cook, 1984). "The dominant voice, the culturally designated professional voice, usually speaks and decides for marginal populations - gender, economic, ethnic, religious, political, and racial minorities - whether therapy is indicated and, if so, which therapy and toward what purpose. Sometimes unwittingly, sometimes knowingly, therapists subjugate or sacrifice a client to the influences of this broader context, which is primarily patriarchal, authoritarian, and hierarchical" (Anderson, 1997, p. xv). Just as power is invisible to those who experience it (White, 1993), I suggest that most family therapists work without much consciousness of their role as cultural and discursive reinforcers.

The dominant discourse of male-female relationships, particularly the "marriage-between-equals" discourse is of particular interest to this study. Hare-Mustin points out that this discourse allows marriage in the United States to conceal the extent of male domination and female subordination. Given this reality, therapists must make very conscious efforts to integrate the subordinate discourse of power differentials based on gender. Hare-Mustin (1994) calls on therapists to develop a reflexive self-awareness that will allow them to work consciously with subordinate discourses.

Subordinate discourses are often marginalized or co-opted, losing their capacity to

influence the dominant discourse (Hare-Mustin, 1994). One example of co-optation offered by Hare-Mustin (1994) is that of the peace symbol. Once a symbol of counter-cultural activism, it has been reduced to a common piece of jewelry.

I suggest that the "domestic violence, wife-abuse, child-abuse" discourses are additional subordinate discourses that have been equally co-opted. They have been co-opted by their incorporation into dominant cultural discourse. I suggest also that this co-optation has been so effective that even a feminist informed scholar of Hare-Mustin's ken has remained unaware of it. In 1994 Hare-Mustin wrote "...some marginalized discourses, such as those of wife abuse and child abuse, have been brought, through feminist efforts, out of the private realm of the family and into increasing public awareness" (p. 21). I suggest that these "domestic violence" discourses have been created and adopted by the mainstream, in part, because they obscure the impact of male violence and reinforce the dominant, and false, discourse of marriage-between-equals. Rhetoric like "battered woman" or "domestic violence" and particularly "family violence" situates the violence within the family system without assigning agency to the perpetrator. The problem of violence becomes systemic, with no family member and every family member responsible.

Another very recent article supports this idea that feminist discourse has been co-opted. Riley (2001) notes that in the past decade a trend has emerged in which feminist values are supported while feminists themselves continue to be constructed negatively. This separation of feminist values from feminists themselves functions to minimize the impact of feminist scholarship on the dominant discourse.

In a study of linguistic avoidance in journal articles about male battering of females, Lamb (1991) reviewed 11 journals across four disciplines. She looked for language that obscured the attribution of responsibility in cases of violence against wives. She looked for language describing victims without agents such as "abused" or "battered" women. Articles in family therapy journals ranked highest in the category of diffusion of responsibility. The battering of women by men was described as any of the following: spouse abuse, marital aggression, couples' violence, violent relationships, parental violence, conjugal violence, family violence, and domestic disputes. This common clinical rhetoric effectively removes responsibility for the violence from the individual and places it in the systemic interaction of the family members.

A 1999 study, described in the article "Patient Was Hit in the Face by a Fist... A Discourse Analysis of Male Violence Against Women" (Phillips & Henderson, 1999), supported Lamb's (1991) findings. In this study 165 abstracts and 11 full-length articles from the professional and popular literature describing male violence against women were analyzed. "Male violence" was found to occur only eight times and male gender was infrequently mentioned. Female gender was often noted in the identification of victims.

My own research with clinical supervisors confirms that many clinical supervisors in Iowa use language that obscures personal responsibility for violence (Adams, 2000). 23 clinical supervisors in Iowa were presented with the previously cited Hansen and Harway (1991) case study vignette:

> Carol and James have been married 10 years. They have two children, Dana, 9, and Tracy, 7. James is employed as a foreman in a concrete manufacturing plant. Carol

> also is employed. James is upset because on several occasions Carol did not return home from work until two or three in the morning and did not explain her whereabouts to him. He acknowledges privately to the therapist that the afternoon prior to the session he had seen her in a bar with a man. Carol tells the therapist privately that she has made efforts to dissolve the marriage and to seek a protection order against her husband because he has repeatedly been physically violent with her and the kids, and on the day prior, he grabbed her and threw her on the floor in a violent manner and struck her. The family had made plans to go shopping, roller-skating and out to dinner after the session.

Study participants were asked to respond to the question, "What is going on in this family?" Responses of the 10 clinical supervisors who responded to the study invitation included: (a) abuse and physical violence; (b) violence in family: (c) both parties are trying to triangulate the therapist to make the other look bad; (d) domestic violence effecting all family members; (e) possible neglect by the mother; (f) both partners see the other as the problem; (g) child abuse; and (h) James' behavior is inappropriate.

Only two participants used language that gave agency to James for the violence.

One participant responded "wife fears husband's future violence toward herself and children." The other participant stated, "physical abuse by James, conflict avoidance by Carol." Even in naming that James was the agent of violence toward Carol and the children, this participant still did not state that Carol was fearful and avoiding James. rather, Carol was avoiding conflict.

This kind of linguistic obfuscation should be of grave concern to therapists. The memory of trauma is "wordless," and the healing role of the therapist is to help provide the words (Herman, 1992). A survivor writes, "... I have learned that in order to become an 'author' - that is, to develop the courage to risk linguistic self-assertion - it is necessary to put 'unspeakable acts' into words" (Daly 1998; p. 14).

Dorothy Allison's autobiographical fiction Bastard Out of Carolina (1992), a national bestseller and National Book Award Finalist, is a novel that provocatively narrates "unspeakable acts." Allison, herself a survivor of sexual and physical abuse, tells the story in the voice of twelve-year old Ruth Anne Boatwright, known as Bone. Bone is the victim of repeated sexual and physical abuse perpetrated by her stepfather, Daddy Glen.

In the following excerpt, Bone describes one particular beating and her mother's response. Just prior to this passage, Bone has learned of the death of a favorite aunt: My head ached so bad I didn't even hear Daddy Glen shout. I was still curled up on the porch when he stepped through the front door.

"I was calling you, girl." He grabbed me by the shoulder. He hadn't had time to shower yet, and his face was still sweaty, his uniform smelling of spilled milk. I looked up at him with hatred and saw the pupils of his eyes go small and hard.

"I didn't hear you," I said plainly, coldly.

"You damn well did." He pulled me up to my feet.

"I didn't," I yelled at him. My blood was pounding in my head. "I didn't hear you. You ain't got no business calling me a liar." Through the open door I could see Mama come out of the kitchen, wiping her hands on a towel.

"Glen," she called. "Glen."

"You think cause your aunt died you can mouth off to me?" Daddy Glen was almost spitting with rage. "You think you can say just anything you damn well please! You got another think coming."

He dragged me into the house... "Glen," Mama called again, coming after us, but he didn't stop. My shoulder hit the doorjamb as he pushed me ahead of him into the bathroom. I stumbled and would have fallen on the floor, but he was still hanging on to my arm. The door slammed behind us.

"Glen! Don't do this, Glen!" Mama's hands beat on the bathroom door.

I stood, looking up at Daddy Glen, my back straight and my hands curled into fists at my sides. His features were rigid, his neck bright red. He kept one hand on me while he pulled his belt out of its loops with the other...

He pinned me between his hip and the sink, lifting me slightly and bending me over...No. No. No. He was raging, spitting, the blows hitting the wall as often as they hit me. Beyond the door, Mama was screaming. Daddy Glen was grunting...The belt went up and came down. Fire along my thighs. Pain...

Afterwards it was so quiet I could hear my own heartbeat. Sound came back slowly. There were speckles of blood on the washcloth when Mama rinsed it. I watched, numb and empty. I was lying against her hip, on their bed...

"Why, honey? Why did you have to act like that? The funeral's tomorrow, Raylene's expecting us to help clean up at Ruth's before everybody goes back over there, Alma's baby's sick, and now..." She put the cool cloth on my neck.

"Bone. Is it because of Ruth? Is that why you started yelling at Glen? Honey, you know you can't do that."

...I heard her whisper as if she were talking to herself, "I just don't know what to do." I closed my eyes. There was only one thing that mattered. I had not

screamed.

In using Bone's voice to tell the story of Daddy Glen's violence, Allison privileges Bone's experience and perspective. The violence and its impact are clear, the "unspeakable acts" clearly spoken. Nothing is obscured, there is no minimization (Daly, 1998).

Allison's Bastard Out of Carolina was published the same year as the previously noted Thousand Acres (Smiley, 1992), in which the voice of the victim was silenced. Smiley's work won both the 1992 Pulitzer Prize and the National Book Critics Award. It has been suggested that while Allison's is in fact the better crafted novel of the two, that Smiley's work was bestowed those honors because she stayed within the bounds of the dominant discourse in privileging the voice of the father (Armstrong Randolph in Daly, 1998).

Are we repeating historical patterns of denial? Phillips and Henderson (1999) note that "a kind of sleight of hand occurred when this public naming of male violence against women as a crime was cast into the form of wife-beating and rape. . . . Originally named wife abuse, male violence against women quickly became spousal abuse, marital violence, family violence and domestic violence." (p.120).

Historical patterns of cultural acknowledgement of interpersonal trauma take the form of active recognition and investigation followed by obfuscation, omission and denial (Herman, 1992, van der Kolk, 1996). This pattern is attributed to the fact that too much discomfort is created when individuals and societies are called upon to address the responsibility of the perpetrators for the violence.

"Like the victims of trauma who banish their suffering into the oblivion of amnesia, students of psychiatry and psychology have denied the horrors of interpersonal brutality, cruelty, and exploitation, by an unconscious selective focus on the other paradigms...that do not require us to struggle as openly with the existential and spiritual questions raised by suffering" (Bowman & Chu, 2000, p. 2).

Implications for Research

Concerns about power differentials and neutrality are not unique to the field of Family Therapy. As a passionate advocate and a passionate researcher, I find myself in the midst of a controversy about notions of power, neutrality and objectivity in research as well as in therapy.

The core issues of the controversy are illuminated in three short commentaries in the March 1994 issue of Family Process (Jacobson 1994, Avis 1994, & Gelles 1994). One voice is that of positivist empiricists who maintain that "Academic research is, and should be, objective and dispassionate... The standards for evaluating the worth of research should be the traditional rules of logic, scientific method, and data analysis. Advocacy is passionate" (Gelles, 1994, p.95).

Good research, apparently, is without passion. Yet, part of good research is good writing, and good writing is nothing if not evocative. Good writing has the capacity to move us to understandings that are experiential and affective as well as intellectual. And is that not, essentially, the goal of good qualitative research - to be able to convey the essence, or the central and underlying meaning, of an experience ? (Cresswell, 1998)

"... writers may wish to distance themselves from the discomfort they feel with the graphic details of a man physically harming a woman, which are inevitably evoked by good writing. Journal authors may therefor cling to the norms of academic writing in an effort to avoid disturbing either themselves or their readers with emotion-laden language. It is also, paradoxically, the case that such language .... may sound more like fiction than fact and may thus undermine the truth of what is said" (Lamb ,1991, p.255).

Why, I wonder might it "sound more like fiction than fact?" Because there is so little academic writing about the reality of violence in families that accurate representations appear contrived?

I suggest it is impossible to truly understand and communicate the subjective reality of victims, survivors and perpetrators of violence in families without emotion. "An epistemology which excludes emotions from the process of attaining knowledge radically undercuts women's epistemic authority" (Tompkins, 1987 as noted in Daly, 1998, pp. 18, 127).

Feminists and social constructionists hold that it is impossible "to obtain an objective account of the world... not mediated by our language, by our interpretations, by our location in the field of social structures" (White, 1992, as cited by Avis, 1994).

I find Judith Meyers Avis' (1994) comments in support of the researcher as advocate to be particularly helpful. She illustrates the severe limitations of the positivist empiricist research approach and how its illusion of research neutrality functions to privilege the perpetrator perspective. Avis cites "one of the most controversial findings in the history of wife abuse research", the findings of Straus, Gelles, and Steinmetz that

"within the family women are about as violent as men" (Strauss, 1992 as cited by Avis, 1994). She notes that the study was widely criticized for poor internal validity, and that "categories of violence did not differentiate between threatened, attempted, and actual violence, and did not take into account severity of injury, intent, or self-defense. The research also failed to consider the context of the violence, collected information from only one partner, and included only couples currently living together.

The researchers' conclusion that "husband beating" is as prevalent a problem as wife beating constructed a new reality of "battered husband syndrome" and of women who are equally as violent as men in the home. The wide publication and political use by others of this construction has cost the battered women's movement dearly... Some of the hidden value assumptions that created problems with this research might well have been avoided had advocates and formerly battered women been consulted during the design process" (Avis, 1994).

Many qualitative research papers include a section titled, "Researcher as Instrument," or "Researcher as Tool." While it may be that inclusion of such sections is intended to support the social constructionist view that the researcher can not be separated from the study, I suggest that such inclusion is paradoxical in its function. To isolate discussion of myself as "research tool" within one section of a larger section discussing research methodology reflects a positivist empiricist assumption that the researcher and the research method can be experienced as separate entities, one nesting within the other.

Additionally, such discussion of "researcher as tool" assumes that such discussion

will inoculate the study against unconscious bias. In fact, it may do just the opposite – creating the illusion of informed subjectivity when many researchers are in fact completely unaware of how they are influenced by sexism and androcentricism. "Objectivity has not been 'operationalized' in such a way that scientific method can detect sexist and androcentric assumptions that are the 'dominant beliefs of an age' – that is, that are collectively (versus only individually) held" (Harding, 1994).

In fact, the very use of the phrase "self as research tool or instrument" implies that the researcher has an objective experience of self to draw on, and that the "self" can be differentiated from the researcher and manipulated to bring about particular desired results. It further implies that this apparent bio-metaphysical separation then allows the researcher to wield the tool of self, thus somehow rendering the researcher more potent in the academic dissemination of knowledge.

Precisely because it is both empirically impossible, and a "weak" research stance (Harding, 1994), to separate the researcher from the research, I have incorporated commentary from my own experience in this literature review and will continue to do so in the following pages.

While having had the luxury of growing up in a home without violence, my clinical work with violence in families is extensive, and my convictions about how therapists should respond are strong. Therapists should always be screening for violence, should recognize violence in families, and should work with clients from a "safety first" perspective.

I have been witness to the pain, confusion, and self-doubt of those who have been in therapeutic relationships where the abuse was minimized, dismissed, or ignored. I have sat for what seemed like years (and sometimes was) with people who were understandably afraid to speak their own truths. I have also had the privilege of being witness to the healing that comes from the hard won personal empowerment that those same survivors of violence in families experience in their recovery.

For more than 10 years, I worked directly with victims and perpetrators of violence in families in my clinical practice. For 7 of those years I also supervised MFT's and ICSW's who worked with violence in families. I have also provided training for clinicians who work with violence in families and with adult survivors of severe childhood abuse.

I have also experienced the classic symptoms of vicarious trauma that are common for therapists working with violence in families (Iliffe & Steed, 2000). I have gone through significant shifts in my own cognitive schema and worldview. I no longer believe we live in a society of equals, no longer take safety for granted, and have an acute awareness of my own powerlessness in the face of dominant cultural forces. Peer support, case debriefing, continuing education, social activism, and the support of family and friends have helped me in my conscious efforts to maintain a balanced, yet realistic perspective; and to exercise the personal power that I do have.

My own convictions about clinical work with violence in families are strong. I experience myself both as an advocate for victims and survivors of violence in families, and as an advocate for increased therapist competency. Our primary goal in working with

violence in families must be to work toward safety. Then, and only then, should we look beyond that goal. The clarity with which I make that statement implies simplicity. But working with violence in families is far from simple, and securing safety is often a long and arduous task for client and therapist alike.

Summary

In summary, thorough review of the literature determines the following:

Violence in families is a gendered phenomenon of grave social concern.

Family and couple's therapists respond poorly to violence in families. This poor response takes two forms. A significant number of therapists do not recognize violence in families, and a significant number of therapists intervene without respect for power differentials when violence is recognized.

Language creates, reinforces and reproduces meaning and reality. The language of the dominant discourse on domestic violence obfuscates familial power differentials and is part of the problem of poor therapist response to violence in families.

Discourse analysis is a relatively new qualitative method of inquiry that seeks to illuminate how a particular phenomenon is constituted through written and verbal practices, with particular emphasis on identifying the social consequences of those practices.

Discourse analysis of linguistic avoidance in journal articles about male battering of females, found language that obscured the attribution of the men's responsibility, as well as language that noted the female gender of the victim/survivor while obscuring

the male gender of the perpetrator.

Approved Clinical Supervisors are responsible for ascertaining that AAMFT credentialed family and couple's therapists have competency in working with power differentials in families. Yet there is no empirical evidence regarding the expertise of clinical supervisors themselves in this area.

Qualitative research methods, based on feminist constructionist views including researcher as advocate, are appropriate when researching issues related to violence in families.

Research Questions

From review of the literature coupled with my own interests and curiosities, the following research questions emerged:

How do AAMFT Approved Supervisors conceptualize, and recommend intervention for a case vignette describing the perpetration of severe violence in a family?

Does the gender of the perpetrator of the violence in that case vignette influence AAMFT Approved Supervisors' conceptualizations and recommendations?

Does the awareness of the AAMFT Approved Supervisors reflect or contradict reports in the literature regarding poor MFT response to violence in families?

RESEARCH METHODS

Feminist Phenomenology

"In the postmodern view, reality - even so-called scientific reality - is woven and rewoven on shared linguistic looms " (Hoffman, 1997, in Anderson, p. xii).

Phenomenology studies lived experience, asking, "What is the experience, and how it is evidenced?" (Creswell, 1998) This study sought to develop a greater understanding of how some Approved Supervisors conceptualize and intervene with violence in families as evidenced by their discourse.

Some specific reasons for utilizing a phenomenological approach when exploring interventions with violence in families have been noted by Eisikovits (1996). These reasons apply as well to the exploration of the larger phenomenon of therapist awareness of violence in families. In particular he notes that the phenomenological approach is well suited because of its descriptive power. It has the power to provide information from a multiplicity of perspectives with competing explanations. The classic phenomenological approach asks the researcher to "state presuppositions and to 'bracket' or suspend these preconceptions in order to fully understand the experience being studied without imposing an a priori hypothesis" (Reimen, 1986, as cited in Creswell, 1998, p. 277).

The limitations of this approach have already been addressed at length, and will not be further discussed. Rather, I adopted a "feminist phenomenological" theoretical framework that allows for the researcher's lived experience to be consciously and transparently incorporated into the study. This approach is consistent with that part of the phenomenological tradition that demands the use of an ongoing and active reflective

stance of critical examination (Eisikovits, 1996).

In keeping with both the recursive nature of all qualitative research, and the social action emphasis of feminist scholarship, a key goal in this "feminist phenomenological" methodology is to increase awareness of the very serious problem that our field has in poor MFT response to violence in families.

Typically phenomenological studies utilize broadly focused in-depth interviews of 10 to 20 participants. In this study's modified phenomenological approach, I utilized a data gathering technique that is more commonly found in quantitative research, tightly focused e-mail surveys. I structured a very simple, two question, e-mail survey using a case vignette used by Harway, Hansen and Cervantes (1991, 1997) in their studies of MFT response to violence in families.

The previously discussed debate in the literature regarding gender symmetry piqued my curiosity about how gender of the perpetrator might effect participant response. I changed the agent of perpetration from the male partner to the female partner in the survey sent to half of those invited to participate. Everything else in the vignette remained the same.

Through use of these e-mail surveys, a much larger pool of participants was obtained and participants were afforded the opportunity to consider the research questions at their leisure. They also had the opportunity to review their responses and to make changes to them as they saw fit before submitting them for research review. This opportunity for self-editing contributed to the overall trustworthiness of the research

results. This data collection method also allowed for the elimination of the transcription process necessary when working with oral interviews.

Additionally, in using e-mail I was able to alert 195 Approved Supervisors to the concerns of this research project. The results of the study were made available to all 195; and regardless of whether or not they participated in the study, they were invited to contribute to discussion about the research design and study results on an online discussion board created for this purpose.

Critical Discourse Analysis

Data was reviewed using critical discourse analysis. Critical discourse analysis (CDA) is an approach that studies how the abuse of social power is actualized, replicated and resisted by language. CDA analysts take explicit positions, seeking to understand, expose and change social inequalities (van Dijk, 1998). CDA addresses social problems, holds that discourse constitutes society and culture and that power relations are discursive. CDA is interpretative as well as explanatory, and is itself a form of social action (Fairclough & Wodak, 1997 as cited by van Dijk, 1998).

While for centuries the natural sciences have been constructing special task research activities to reveal particular aspects of phenomena, the argument remains that responses to questionnaires do not adequately reflect in situ realities; and that there is risk that behavior under research conditions differs from that in vivo (Lemke, 1998, p. 1). Because discourse is not situation specific but community specific, a critical discourse

analysis approach minimizes some of that risk. Additionally, oral discourse is very seldom directly analyzed, but is transcribed.

Formal approval from the Iowa State University Human Subjects Committee was received for all procedures.

Data Collection

Participants

Potential participants were chosen through a process of convenience sampling. Contact information was obtained from AAMFT. As part of a pilot study, regular mail addresses of AS's in Iowa were obtained from the AAMFT list of AS's. 23 of the 26 approved supervisors in Iowa were then invited by regular mail (with 2 mailed follow-ups and one phone call follow up) to complete the male perpetrator version of the survey. 10 completed surveys, for a return rate of 44%.

Additionally, 172 approved supervisors were invited to participate by e-mail with two email follow-ups (Appendix B). Their e-mail addresses were obtained from the members only section of the AAMFT web site where member information is provided in alphabetical order. The first 172 AS's who provided e-mail addresses where chosen for this study. Half, or 86, were sent the vignette presenting the male as the perpetrator. Completed surveys were returned by 25 for or a return rate of 29%. The other half were sent the vignette presenting the female as the perpetrator. Returned surveys were received from19, for a return rate of 22%. Additionally, 19 supervisors responded by providing

reasons for their non-participation, and 2 individuals who did complete surveys also provided possible reasons for the non-participation of others.

A total of 195 approved supervisors were invited to participate. Overall the study reviewed completed surveys from 54 participants, for a 28% participation rate. This return rate is low for a survey with two follow-ups (Dillman, 2000), and will be further addressed in the discussion section. 25 participates identified themselves as male, 24 identified themselves as female, and 5 did not provide information about gender. 44 participants identified themselves as white or Caucasian, 4 identified themselves either as African American, Latina, Latino, or Creole, and 6 did not provide information about race.

Data Collection Instrument

In e-mail conversation with Michele Harway (2001), I asked about the vignette's creation. I learned that she and her co-author Marsali Hansen, created this case vignette from public information about an actual Pennsylvania court case. The husband was convicted of murdering his wife after using what was reported as the "bitch deserved it" defense. The researchers included all the descriptive information available to them in creating the vignette. To their knowledge, the couple did not actually seek therapy. Information about therapy was the only information they inserted into the vignette that was not in the original case information. A copy of the survey, including the case vignette, is available for review in Appendix C.

Procedure

The recommendations of Dillman (2000) for data collection through the use of e-mail were followed. Participants were sent an e-mail explaining the study and informing them that they would receive another e-mail with a short survey in two days.

Two days later, the e-mail with the questionnaire was sent. Return of completed questionnaires was acknowledged immediately in an e-mail thanking participants for their time and consideration and informing them that study results would be e-mailed to them.

One week after the questionnaires were e-mailed, another e-mail with the same version of the questionnaire was sent to those who had not yet responded. This procedure was repeated until each invited participant had either responded or had received three e-mails containing the questionnaire. Dillman (2000) reported a response rate of 60% with this procedure.

Low response rate to an initial e-mailing to 72 approved supervisors, administrative directors of COAMFTE programs, yielded only 17 completed surveys. A second round of e-mailing to an additional 100 supervisors yielded an additional 27 completed surveys. An additional 10 surveys completed by Iowa Approved Supervisors as part of a pilot study for this research, were obtained following Dillman's (2000) recommendations for use of regular postal services.

Data Analysis

Qualitative Analysis

To answer the research question, "How do the Approved Supervisors in this study conceptualize, and recommend intervention for a case vignette describing the perpetration of severe violence in a family?", the following procedures were used.

I read each response as it was returned. Either upon receipt, or shortly after, each response was copied into tables created in Excel files, and assigned identification codes. The first number in the identification code was categorical, referring both to the data collection group from which the response came, and to the gender of the perpetrator in the vignette. The second number in the identification code was simply a unique identifier assigned ordinally.

The data was analyzed based on a rigorous step-wise process developed by Colaizzi (1978). This process was chosen in part because it provides for checks on the key components of trustworthiness in qualitative research as outlined by Lincoln and Guba (1985): credibility, transferability, dependability and confirmability.

Step 1 Overview: To develop a sense of the data, I read the responses as they were returned, as they were entered into data files, and again read them as a collection.

Step 2 Extracting significant statements: Significant phrases and sentences were noted and recorded separately.

Step 3 Formulating meanings: I transferred the meanings of those recorded bits of information into my own words.

Step 4 Clustering themes: Clusters of themes were formed based on the meanings

made in the previous step. The raw data was then compared with the themes through repeated reviews. In the course of these reviews, steps 2, 3 and 4 were repeated.

In the course of the first formal review, each sentence was reviewed specifically for the presence of words or phrases indicative of a cluster of themes regarding the violence, that emerged in the pilot study for this research (Adams, 2000): (a) a theme regarding acknowledgement of the violence; (b) a theme regarding acknowledgement of agency for the violence; and (c) a theme regarding acknowledgement of the need to address safety concerns.

As each sentence was reviewed, it was coded either "yes" or "no" for the presence of each theme. In the course these reviews, a number of additional emergent themes clustering around the issue of intervention were noted.

In the course of the second formal review, the data was again reviewed by each participant's full response and then by collection group, with these possible themes regarding intervention in mind: (a) a theme regarding the reporting of the child abuse described in the vignette; (b) a theme addressing the gravity of the violence and/or the immediacy of the need for intervention; and (c) a theme addressing the use of alcohol.

Sentences were then again reviewed one at a time and coded either "yes" or "no" for the presence of each of the these themes.

In the course the second review, coding for the themes in the first review was checked. As themes clustering around violence and agency were checked, sub-themes clustering within categories (i.e. violence addressed, violence not addressed) began to emerge.

A third formal review of each sentence was again done with the question, "What is the theme of this particular sentence?" in mind. The following focuses emerged: (a) violence, battering; (b) abuse; (c) conflict; (d) anger; (e) power; (f) control; (g) therapist triangulated, client veracity questioned; (h) non conflict other (generally relating to couple relationship): (i) more information needed; (j) aggression; (k) destructive behavior; (l) violence addressed as secondary focus. Each sentence was assigned a code representing one of these sub-themes.

A fourth formal review was then undertaken to determine the primary theme of each participant's response overall. While the rate of occurrence of each of the above sub-themes was noted, it was not the determining factor in deciding on response theme. That determination was made based on emphasis in the response. For example, a response that had a preponderance of sentences focusing on the couple's relationship (non conflict other) might have been coded as "violence primary focus" because the response began with the statement, "Addressing the violence and developing a safety plan is the most important thing here. Only after that would other issues be addressed."

The fifth formal review was an accuracy check. All data was reviewed again on both a sentence by sentence basis, and on entirety of response.

Identification numbers and response codes were then entered into the SPSS statistical program. Frequencies were run and checked against the frequencies determined by the Excel program. To further assure trustworthiness in this research, all data with response codes is available for review by the reader in Appendix D.

Step 5 Thorough description: A thorough description of this data analysis

follows in the results section.

Step 6 Validation step: All who were invited to participate in this study were sent an e-mail (Appendix B) inviting them to visit a web site here information about the study and preliminary results were posted. They were encouraged to post their comments about the study on a discussion board. A complete copy of this web site is available for review in Appendix E. All were also informed that if they preferred they could simply send their comments directly to me by e-mail.

Quantitative Procedures

To answer the research question, "Does the gender of the perpetrator of the violence in the case vignette influence Approved Supervisors' conceptualizations and recommendations?", Pearson's Chi-Square statistical analysis was run on the variables identified by the qualitative analysis. Analysis was run by gender of perpetrator, and by gender of supervisor by gender of perpetrator.

RESULTS

Results of Qualitative Analysis

Table 1 identifies primary themes, and phrases indicative of those themes.

Table 1

Qualitatively identified themes with coding examples

Violence: Was the violence addressed?	
Yes	No
"violent outbursts"	"conflict"
"physical abuse"	"abusive situation"
"domestic violence"	"using physical means to control"
"physical violence"	"spouse abuse"
Agency: Was agency for the violence addressed?	
Yes	No
"husband's violence"	"domestic violence"
"Carol has been physically abusive with James"	"the violence"
"violent husband"	"violence of children"
"she is violent"	"physical violence"
Safety: Was safety addressed?	
Yes	No
"augment safety"	Not addressed
"safety planning"	
"safety comes first"	
"intervene for immediate protection of children"	
Child Abuse: Was reporting child abuse addressed?	
Yes	No
"report child abuse"	Not addressed
"report to social services for abuse of child"	
"... mandates a report in this state"	
"if reportable, report"	
Gravity: Was the gravity of the situation / need for immediate intervention addressed?	
Yes	No
"very concerned about ... escalating ... violence"	Not addressed
"safety issues imminent"	
"need for immediate intervention / protection"	

Female Perpetrator Vignette

Of the 19 participants responding to the female perpetrator vignette, 12 (63%) noted the violence, 7 (37%) did not note the violence. 4 (21%) noted agency for the violence, 15 (79%) did not note the agency. 6 (32%) addressed safety concerns, and 13 (68%) did not address the need to establish a safety plan. 6 (32%) stated they would report the child abuse, while 13 (68%) made no mention of reporting the child abuse. 3 participants (16%) made note of the severity of the violence, while 16 (84%) did not address the severity, immediacy of the need for safety, or the crisis nature of the case.

Of the 12 participants who did note the violence, 2 did so secondarily. The theme of one of those responses regarded doubt about the veracity of the information provided by the partners, while the other response focused on the need for additional history gathering by meeting with the couple for two weeks before making any determinations.

The themes in the responses of 3 of the participants who did not note the violence shared an emphasis on conflict, anger, therapist triangulation and secrecy. One stated that "physical methods" were being used to address the conflict. These three participants recommended joint sessions in which the conflicts would be addressed openly. The themes in the responses of the other 4 participants who did not address the violence were: (a) family chaos; (b) conflict, abuse, establish safety; (c) don't know, communication problems, power ; and (d) don't know, aggression, intimacy problems.

16 (84%) discussed the type of therapeutic modality they would employ. 3 (16%) made no mention of therapeutic modality. Of those who did mention modality, 14 (or 40% of the 35 participants) noted they would work individually, or establish safety first

and then decide on the therapy mode. 7 (20%) of the participants stated they would utilize individual and couples therapy without mentioning regard for safety issues.

Male Perpetrator Vignette

Of the 35 participants responding to the male perpetrator vignette, 32 (91%) noted the violence, 3 (9%) did not note the violence. 5 (14%) noted agency for the violence, 30 (86%) did not note agency. 19 (54%) addressed safety, 16 (46%) did not address the need to establish a safety plan. 10 (29%) stated they would report the child abuse, 25 (71%) made no mention of reporting the child abuse. Only 3 participants (9%) made note of the severity of the situation, while 32 (91%) did not address the severity, immediacy of the need for safety, or the crisis nature of the case.

Of the 3 participants who did not note the violence, 2 participants stated that more information was needed than what was provided in the case vignette in order for them to respond. The third participant who did not note the violence stated the vignette described "destructive behavior" and emphasized further assessment and establishing safety.

21 (60%) mentioned the kind of therapeutic modality they would employ. 14 (40%) made no mention of therapeutic modality. Of those who did mention modality, 14 (or 40% of the 35 participants) noted they would work individually, or establish safety first and then decide on the therapy mode. 7 (20%) of the participants stated they would utilize individual and couples therapy and did not make mention of the safety issues.

These findings are summarized in Table 2.

Table 2

Qualitatively Identified Themes and Their Rates of Occurrence by Perpetrator Gender

Theme	Total		Female Perpetrator Vignette (n=19)		Male Perpetrator Vignette (n=35)	
	n		n		n	
Violence						
Noted	44	.81	12	.81	32	.91
Not noted	10	.19	7	.37	3	.09
Agency						
Noted	9	.17	4	.21	5	.14
Not noted	45	.83	15	.79	30	.86
Safety						
Noted	25	.46	6	.32	19	.54
Not noted	29	.54	13	.68	16	.46
Child Abuse Report						
Noted	16	.30	6	.32	10	.29
Not noted	38	.70	13	.68	25	.71
Gravity / immediacy						
Noted	10	.19	3	.16	7	.20
Not noted	44	.81	16	.84	28	.80
Therapeutic modality						
Noted	37	.69	16	.84	21	.60
Not noted	17	.31	3	.16	14	.40
Individual	19	.35	5	.26	14	.40
Couples	18	.33	11	.58	7	.20

Reasons For Non-Participation

20 of the 172 participants who were invited to participate by e-mail were kind enough to let me know their reasons for not participating in this research. Additionally, 2 individuals who did complete surveys shared their ideas about possible reasons for non-response. Six primary themes emerged in review.

Misplaced survey: 1 individual reported that "the survey had been misplaced"

Get too many research requests: 5 individuals reported something similar to this quote, "I can't tell you how many requests I get and how busy I am. I do my best to respond to what I can."

The survey demands too much time: 13 individuals reported something similar to these quotes, "Your (survey is) ... interesting but requires me to think, time for which is in short supply," or "Answering these questions will take much more time than stated."

Case vignette does not provide enough information: 5 individuals provided responses fitting this theme. For example "There is not enough information provided to answers the questions -- more clinical data is needed."

Research project is not sound: 5 individuals provided responses fitting this theme. For example, "I did not respond to your survey because I saw absolutely no relevance to supervision. How I conceptualize cases myself has very little to do with how I help others conceptualize them." Or, "The answer to your question, why I didn't respond, can be found in your statement.' Please keep your responses to questions 1 and 2 brief.' How??" Another expressed concerns about the confidentiality of e-mail and trust regarding how I

would maintain confidentiality and manage returned e-mails. In spite of my detailed response to those concerns, the individual chose not to participate.

Participant anxiety, trust concerns: 1 individual, who did participate, suggested, "there is a fear of being judged based on the factors of gender and race and the concern that the data won't be accurate or that whatever conclusions you reach won't be valid or true based on this scenario that has been presented...."

Results of Quantitative Analysis

To answer the research question, "To what extent does the gender of the perpetrator of the violence influence that conceptualization and intervention?", Pearson's Chi Square, crosstab statistical analyses were run on the variables (themes) identified in the qualitative analysis. Appendix F contains statistical tables.

No statistically significant differences ($p > .05$) were found by group, or by gender by group, for the following themes: (a) assignment of agency (b) reporting child abuse (c) use of gendered language (d) addressing gravity, and (e) addressing therapy mode.

Statistically significant differences ($p < .05$) were found with regard to (a) noting the violence by gender of perpetrator (b) noting the violence by gender of perpetrator and gender of supervisor, and (c) addressing safety by gender of perpetrator and gender of supervisor.

Overall, supervisors who reviewed the male perpetrator vignette were more likely to address the violence than supervisors who reviewed the female perpetrator vignette,

X^2 (1, n = 54) = .6.52, p=.01. 91% of those who reviewed the male perpetrator vignette noted the violence. 63% of those who reviewed the female perpetrator vignette noted the violence.

Further analysis revealed that male supervisors who reviewed the male perpetrator vignette were significantly more likely to note the violence than male supervisors who reviewed the female perpetrator vignette X^2 (1, n = 54) = 4.96, p = .026. 55% of the male supervisors who reviewed the female perpetrator vignette noted the violence, while 93% of the male supervisors who reviewed the male perpetrator vignette noted the violence.

71% of the female supervisors who reviewed the female perpetrator vignette noted the violence, while 88% of the female supervisors who reviewed the male perpetrator vignette noted the violence. Statistical analysis determined that there was not a statistically significant difference in these percentages, X^2 (1, n = 54) = 1, p = .315.

With regard to addressing the need to establish safety, overall there was not a statistically significant difference between supervisors who reviewed the male perpetrator vignette and those who reviewed the female perpetrator vignette. Further review by gender of supervisor did reveal statistically significant results. Male supervisors who reviewed the male perpetrator vignette were more likely to address safety concerns than male supervisors who reviewed the female perpetrator vignette, X^2 (1, n = 54) = 4.74, p =.03). 9% of male supervisors who reviewed female perpetrator vignettes addressed safety. 50% of the male supervisors who reviewed male perpetrator vignettes addressed safety.

71% of the female supervisors who reviewed the female perpetrator vignette addressed safety, while 65% of the female supervisors who reviewed the male perpetrator vignette addressed safety. This difference, however, was not determined to be statistically significant, X^2 (1, n = 54) = .101, p = .751.

Statistical analysis tables are available for review in Appendix D.

Internal Validity

Member Check

While all invited participants were asked to share their thoughts about the study and the study results, only one individual chose to do so. That individual expressed concern about the study stating that it was not necessary to note agency in answering the questions as agency was noted in the vignette.

It appears that relatively few chose to visit the web site reporting the study results. Two weeks after posting, the site counter reported 175 hits. At first glance this number appears to be significant, but it is misleading. There were unanticipated problems with the hit counter. A hit was registered each time any page of the web site was accessed. The site has 12 pages. One individual browsing the entire site would register 12 hits on the counter. Additionally, I generally visited the site 2 times daily to check for postings to the discussion board. Each time I visited a hit was registered when I accessed the home page and another hit was registered when I accessed the discussion board. Consequently it is not possible to determine with any accuracy how many individuals actually reviewed the study information.

Peer Check and Interrater Reliability

To assure consistency both across time and between peers, a second reviewer coded a random selection of 20% of the participant responses. This reviewer was an MFT Ph.D. student with research training and clinical experience. Interrater reliability was 93%.

DISCUSSION

This study began with two goals. The first was to explore to what extent the awareness of AAMFT Approved Supervisors reflects and/or contradicts the reports in the literature regarding the poor awareness that MFT's have regarding violence in families. The second goal was to encourage discussion, and to increase Approved Supervisors' awareness of the very serious problem that the field has in poor MFT response to violence in families.

The first goal was met and will be further discussed below with attention to specific research questions. Achievement of the second goal is less clear.

In smaller, strictly qualitative studies, the researcher is able to develop a relationship with research participants, and it is in the course of that relationship that the recursive process of discussion occurs. The design of this study precluded the development of personal relationships, which may account for low participation in discussion.

Participation Rate

A relatively low participation rate was of concern. Dillman (2000) reports a response rate of 60% in questionnaire and survey research using the procedures followed in this study. The response rate in this study was closer to 30%.

Trust in Researcher

Of the reasons provided for non-participation I am most intrigued by a reason proposed by an individual who did participate: that the nature of the questionnaire may have generated some discomfort, perhaps even created anxiety about how responses and ultimately the participant would be judged. In retrospect, I reviewed Dillman (2000) and realized that the questionnaires and surveys noted for the most part are asking participants to report subjective information. The questionnaire in this study was very different. Participants were asked to report how they conceptualize and process information that directly reflects upon their professional expertise. It is now not surprising to me that the response rate was significantly less than anticipated. Discomfort may also help account for the low level of participation in discussion of the research results.

Concern about judgements related to gender issues may also account for the fact that fewer female perpetrator vignette surveys were returned than male perpetrator vignette surveys. With 54 total responses the expected n for each perpetrator gender was 27. 35 returned male perpetrator vignette surveys, while 19 returned female perpetrator vignette surveys.

Additionally, issues of power and authority may have influenced the low response rate. This study invited AAMFT Approved Supervisors to provide me with information that would reflect on their expertise. Many of the Approved Supervisors are also academicians with Ph.D.'s. At the time of the study, I had neither AAMFT supervisory

credentials nor a Ph.D., which may also have limited trust in my ability to accurately evaluate their responses.

Adequacy of Information

A secondary reason provided for non-participation was that there was not enough information in the vignettes to provide for adequate response. Granted, it is not practically possible or ethically responsible to develop long-term treatment plans with such limited information, and without the participation of the clients. The information provided did, however, furnish more than enough information for immediate, crisis focused intervention. The vignettes were very specific in stating that violence was being perpetrated both toward an adult and toward children, and that that violence had been perpetrated as recently as the day before the therapy session. Given that information, a therapist should be able to outline the basic protocol for working with violence in families (e.g. Campbell, 1995, Strauss, 1996, Buchbinder, 2000): acknowledge the perpetration of the violence to the victim, assess danger while prioritizing safety, and address the mandated reporting of child abuse.

Salience

Another reason expressed for non-participation was the belief that the study had nothing to do with supervision. 2 participants expressed this concern. In a comment that denies both logic and the literature (Todd & Storm, 1997), one individual stated, "I did not respond to your survey because I saw absolutely no relevance to supervision. How I

conceptualize cases myself has very little to do with how I help others conceptualize them." In fairness, this statement may be grounded in the belief that supervisors must not impose their clinical style on supervisees. Rather it is the job of the supervisor to help supervisees develop and implement their own clinical styles. The supervisor must, however, question and explore ideas with the supervisee that invite the supervisee to expand his or her understanding of the family being reviewed. I suggest that it is impossible for a supervisor to engage in effective supervision of this sort without drawing on his or her own concepts of the situation. Additionally, the ethical priority of assuring safety overrides any concern regarding imposition of style.

Of value, however, is that this response raises the greater issue of the salience of this study to those invited to participate. In general research response rates increase in relationship to how salient the issue being researched is to those invited to participate in the research (Dillman, 2000). The subject of violence in families continues to be an area of specialization in family therapy, not an area of general interest.

Violence, Safety and Mandated Reporting

Qualitative analysis was undertaken first to answer the question, "How do the Approved Supervisors in this study conceptualize, and recommend intervention for a case vignette describing the perpetration of severe violence in a family?" The answer to this question is alarming.

While most supervisors (81%) indicated that the violence was central in their conceptualization, more than half (54%) of the supervisors in this study did not include

safety concerns in their conceptualizations. Almost three-quarters (70%) would work with the case without addressing the need to report the child abuse. A third (33%) of the supervisors stated they would utilize couples' therapy without any mention of safety concerns. More than three-quarters (81%) would work with the case without any sense of immediacy, in spite of the fact that it was clearly reported that the violence had been perpetrated as recently as the day before the therapy session. At best, these responses reflect ignorance of the basic protocols for working with families where violence is being perpetrated. At worst, they reflect rejection of those same protocols.

Assigning Agency for the Violence

"...it is important that therapists do not make generalizations about situations, but keep in mind the specifics of every circumstance and think ahead to the likely consequences of particular courses of action. This argues for a certain level of 'consciousness' on the therapist's behalf. Further, lest the therapist inadvertently contribute to persons' experiences of oppression, this consciousness requires an appreciation of local politics -- that is, politics at the level of relationships. This consciousness discourages therapists from ...externalizing ... problems such as violence and sexual abuse" (White & Epstein, 1990, p.49).

Eighty three percent of the supervisors in this study conceptualized the case using language that externalized the violence and obscured the identity of the perpetrator. The violence was repeatedly described as an act without an agent. Only 17% of the supervisors in this study used language that assigned agency for that violence to the

perpetrator. This occurred in spite of the fact that 35% made a point to say that individual therapy was the modality they would use. The individual therapy approach may reflect some understanding that the violence is located not in the system but in the individual. If this is the case, the language used by 83% of the participants to describe the perpetration of violence is lacking integrity. It is more consistent with a family systems approach than it is with protocol for intervention with violence in families. This apparent incongruity may be a valuable focus for future studies.

Comparison with Previous Studies

Also an incentive for qualitative analysis was the question "Does the awareness of the Approved Supervisors reflect or contradict reports in the literature regarding poor MFT response to violence in families?" The answer is that it appears to be a bit of both.

In the Harway and Hansen study (1991, n=355), only 40% of their participants acknowledged the violence in the vignette. Twice that percentage (81%) of the approved supervisors in this study acknowledged the violence. One explanation for the significant difference might be that supervisors are indeed more aware of violence in family issues than are the MFT's they supervise. Another explanation may be that awareness overall has increased with a decade's passage of time.

Hansen and Harway reported that 45% of their participants reported that they would intervene as if the situation merited immediate action. In sharp contrast, 19% of the participants in this study addressed immediacy. Eleven percent of the Hansen and Harway participants addressed the need to establish safety, compared to 46% of the

participants in this study. Twelve percent of the Hansen and Harway participants addressed reporting the abuse, though it was not clear to whom, nor whether it was child or partner abuse that would be reported. In the current study, 30% of the participants addressed the need to report the child abuse.

Paradoxically, it appears that the approved supervisors in this study acknowledged the violence in the case scenario twice as often as the MFT's in the 1991 study did, while addressing immediate intervention less than half as often. The supervisors in the current study address safety concerns four times as often as the MFT's, and addressed the need to report of the child abuse more than twice as often.

It is to be expected that supervisors would have greater awareness of clinical concerns in general than MFT's do. So it is not surprising that they appear more likely to name the violence, address safety and report child abuse. It is somewhat surprising that the MFT's in the 1991 study were more likely to address the need to take immediate action than the supervisors in the current study. One reason for this difference may be that the role of the supervisor is in part to refrain from imposing his or her clinical assumptions upon the supervisee, allowing the supervisee time to come to his or her own understandings of a case. With time it is possible that this stance, appropriate in working with supervisees with non-crisis clients, may dull a supervisor's sense of when acute action is demanded.

Caution should be used in discussing these comparisons between MFT's and approved supervisors. The n in the Harway and Hansen study (355), which used only the male perpetrator version of the vignette, was 10 times the n for those who responded to

questions about the male perpetrator vignette in the current study (35). While the same data collection tool was utilized, the Hansen and Harway study utilized regular mail, had a 20% participation rate, and is 10 years old. Additionally, while it appears from review of the literature that coding categories were similar, it is not possible to ascertain that with certainty. Discussion of comparison should only be conducted for the purpose of encouraging further study.

Influence of Gender

Quantitative analysis revealed some interesting gender related differences regarding addressing the violence and safety. Overall, those who reviewed the male perpetrator vignette were more likely to address the violence than those who reviewed the female perpetrator vignette, with male supervisors driving this difference. Male supervisors who reviewed the male perpetrator vignette were more likely to note the violence than male supervisors who reviewed the female perpetrator vignette. Gender of the perpetrator was not a significant determinant for female supervisors noting the violence.

With regard to establishing safety there was no overall difference between those who reviewed the male perpetrator vignette and those who reviewed the female perpetrator vignette. Further analysis by gender of supervisor again revealed a statistically significant difference. Male supervisors were more likely to address safety concerns when reviewing the male perpetrator vignette than they were when reviewing the female perpetrator vignette. No such difference was observed for female supervisors.

Female supervisors, it appears, attach no significance to the gender of the perpetrator when noting violence and safety concerns, while male supervisors do. What might account for this difference?

Violence perpetrated by men is more injurious and lethal than that perpetrated by women. Additionally, male perpetrators generally have more economic and social power in the family system and in society than do women, and can severely traumatize the family by withholding or manipulating that power. It is possible that awareness that the impact of male violence is more severe than female violence might bring supervisors to a greater awareness of male violence and family safety than to female violence and family safety. If that is the case, would it not also be true for female as well as for male supervisors? As it is not true, it appears that a bias by male supervisors is in effect.

Why might men be more likely to recognize the violence of men than the violence of women? Why are women more likely to recognize violence regardless of the perpetrator's gender? I suggest that it is in returning to feminist theory, particularly to feminist standpoint theory (Harding, 1990) that we may find some explanations.

Feminist standpoint theory essentially holds that those with the most social power have the poorest understanding of what it is to live in any given society. Those with the least power have the greatest understanding. White people have less awareness than people of color, men have less awareness than women, members of sexual majorities have less awareness than sexual minorities, etc. The reason for this knowledge imbalance is rooted in the reality that those in power have little experience, or reason to try to experience, the realities of those with less power. Those with less power, however,

have every reason to come to understand both their own experiences in the power strata and the experiences of those who have more power than they have. For some, it is a matter of life and death. For most, it is simply a matter of being able to function in society on a day to day basis.

For example, to succeed as an academician a woman must fully understand and integrate men's way's of knowing in addition to her own. Men, however, if they so choose, can have stellar academic careers without ever understanding or integrating women's ways of knowing.

How might this theory explain the gender-based discrepancy in this study? Feminist standpoint theory would suggest that vulnerabilities with regard to violence are very different for men and women. Women are likely to experience themselves as vulnerable to violence perpetrated either by men or by women. Men, with more physical and social power, are likely to experience themselves as vulnerable primarily to the violence of other men, seldom to the violence of women. Standpoint theory further suggests that men are not as likely to be aware of women's vulnerabilities as women are of men's. This might account for the fact that male supervisors were more likely to address violence and safety when the perpetrator was male, while female supervisors addressed violence and safety regardless of perpetrator gender.

Regardless of theoretical foundation, it is an interesting finding suggesting that gender, and the gender role identification of the therapist, play a part in how therapists understand issues of safety and violence in working with families. The field will benefit from further research into this phenomenon, perhaps focused on gender schema theory,

feminist informed cognitive developmental theory and feminist informed social learning theory.

Limitations of this Study

Generalizability and Transferability

This is by design a modified qualitative study with a small sample. 70% of those invited to participate in this study chose not to participate. Some non-participants did provide reasons for this choice, most did not, leaving non-participant bias for the most part unknown. Consequently, it would be erroneous to draw conclusions about the larger population of AAMFT Approved Supervisors based solely upon this study.

This is, however, not a limitation for this, a qualitative study. "The naturalist does not attempt to form generalizations that will hold in all times and in all places, but to form working hypotheses that may be transferred from one context to another depending upon the degree of 'fit' between the contexts" (Guba, 1992). The hypotheses developed in this study regarding AAMFT Supervisor response to violence in families may be transferred to future studies for further exploration.

Choice of Vignette

While use of the vignette was purposeful and allowed for linking with previous research, it also had its limitations. The vignette did not provide clear information about therapeutic modality and raised questions among many participants about how and why

information was provided to the therapist in the vignette. This lack of clarity may also have precluded response from others.

Further research of this type might benefit from the use of video or audio tapes of therapists working directly with family members. Supervisors might then be asked to critique the therapist's response to the family.

Perpetrator Gender

The characteristics of violence perpetrated by males are very different from the characteristics of violence perpetrated by females. The violence of women is not as severe or lethal, and is often in response to violence perpetrated by men (Johnson, 2000). The vignette described a typical case of severe violence perpetrated by a male, not by a female. In changing the gender identification of the perpetrator, I succeeded in creating a vignette seriously lacking in verisimilitude. Consequently, comparisons between responses to male and female perpetrator vignettes should be noted and discussed only with differences in gendered patterns of violence clearly stated.

Trustworthiness of this Study

The following table summarizes the most basic aspects of research trustworthiness and illustrates how each aspect is demonstrated in qualitative and quantitative research (Guba, 1992; Joanning & Keoghan, 1997). Activities in this study addressing each aspect of research rigor are noted.

Table 3
Aspects of Trustworthiness in Social Science Research

Aspect	Quantitative	Qualitative	Activity in This Study
Truth Value	Internal Validity	Credibility	Research tool linking studies, Peer Check, Data in appendix for audit
Applicability	External Validity	Transferability	Link to previous studies through literature review and research tool
Consistency	Reliability	Dependability	Web site, Peer Check, Data in appendix for audit
Neutrality	Objectivity	Confirmability	Web site, Peer Check, Data in appendix for audit, Suggestions for further research

Conclusion

Results of this study indicate that most of the participating supervisors noted the violence in their conceptualizations, while using language that obscured the identity of the perpetrator. Additionally most indicated that they would not follow basic protocol regarding establishing safety. Of further concern is the fact that most would not report the child abuse as required by mandatory reporting law.

Perhaps as a field we have made some movement. Perhaps more clinicians are recognizing violence as a concern to be addressed in therapy. Results of this study, however, seem to indicate that ignorance about how to intervene continues to be significant.

Of additional concern is the reality that recognizing the perpetration of violence and intervening for safety are only the very first small steps in therapy. Therapists must also

have the expertise to be a healing and guiding presence to individuals and families in the processes of recovery from the trauma inflicted by all forms of violence in families.

A personal history of having been traumatized is a significant contributing factor in a broad spectrum of the human struggles presented to family therapists. A history of trauma is much more common than expected for individuals struggling with the characteristics of personality disorders, major depression, phobias, generalized anxiety, substance abuse, somatoform disorders, and dissociative disorders (Bowman & Chu, 2000).

While the struggles associated with the singular diagnosis of Posttraumatic Stress Disorder (PTSD) alone are often debilitating (Appendix G), PTSD is also associated with significant increases in the likelihood of psychiatric comorbidity. The presence of PTSD elevates odds of being diagnosed with major depression by 4.1 to 6.9 times, and the odds of a social phobia diagnosis by 2.4 times in women and 3 to 7 times in men. PTSD elevates the odds of alcohol abuse or dependence by 2 to 2.5 times, with the lifetime odds of struggling with drug abuse or dependence increasing by 3 to 4.5 times. Further, PTSD significantly elevates the odds of having three or more comorbid psychiatric diagnoses 7.9 times in women and 14.5 times in men (Bowman & Chu, 2000).

The family is the most violent, the most trauma inducing, of all social institutions. Yet, after 20 years of consistently documented concerns, primarily by feminist informed scholars, the COAMFTE still does not require that MFT's be trained in assessment and intervention with violence and trauma in families.

The experience of the adult daughter in the previously discussed novel by Jane Smiley, A Thousand Acres (1993) serves as a valuable metaphor. The daughter's point of view vanished when her father asserted his. The dialogue between the two could just as easily have been a dialogue between a feminist therapist and the fathers of the field of family therapy.

"I've tried to show respect."

"You feminists don't try hard enough... you don't ... make up to us any more. We know what's going on."

"That's not true, ..." I smile. "You're not the easiest to get along with, you know."

"We don't like it when people are lazy, or when they don't pay attention. Marriage and Family Therapy is a hard business, and takes hard work."

I continue to smile... "I don't think you can say that feminists are lazy. Anyway, I don't think you show us any respect. I don't think you ever think about anything from our point of view."

"You don't, huh? We bust our butts working all our lives and we create this great new field for you to make a living in, with a good income, and you think we should be stopping all the time and wondering about your, what did you call it, your 'point of view'?"

Yes, the feminist point of view is valid. From the feminist perspective the field of family therapy is unwittingly reinforcing oppressive discourse with descriptors like "family violence" and "domestic violence" - as if violence was some function of intimacy or domesticity.

The perpetration of violence is a gendered phenomenon of grave social concern. Dominant discourses, reinforced by family therapists, must be illuminated and challenged. Family therapists can, and must move to the forefront of the response to violence in families.

APPENDIX A

APPROVED SUPERVISOR DESIGNATION

The Approved Supervisor designation identifies those professionals who have met the educational, experiential, and supervisory training requirements to supervise marriage and family therapists. Approved Supervisors are professionals with a breadth and depth of MFT clinical and supervisory experience. They are involved in the professional MFT community and are committed to refining their clinical and supervisory skills. Approved Supervisors are mentors who respect, support, and nurture supervisees' resources and strengths in learning environments conducive to professional development. Approved supervisors may work from a variety of MFT theoretical approaches and may practice supervision in many ways. However, all Approved Supervisors must work from a systemic orientation.

The training program for Approved Supervisors involves meeting learning objectives as described below. Approved Supervisors:

1. Are familiar with the major models of MFT and supervision, in terms of their philosophical assumptions and pragmatic implications.
2. Articulate a personal model of supervision, drawn from existing models of supervision and from preferred styles of therapy.
3. Facilitate the co-evolving therapist-client and supervisor-therapist-client relationships.
4. Evaluate and identify problems in therapist-client and supervisor-therapist-client relationships.
5. Structure supervision, solve problems, and implement supervisory interventions within a range of supervisory modalities (for example, live and videotaped supervision)
6. Address distinctive issues that arise in supervision-of-supervision.
7. Are sensitive to contextual variables such as culture, gender, ethnicity, and economics.
8. Are knowledgeable of ethical and legal issues of supervision.
9. Are aware of the requirements and procedures for supervising applicants for AAMFT Clinical Membership.

Standard Track Requirements

The Standard Track is for marriage and family therapists with limited or not experience as a supervisor. The majority apply under this track.

STEPS:

At the time of filing a Training Contract, the prospective supervisor-in-training must have:

- Provided 2,000 hours of post-master's MFT.
- A qualifying graduate degree in a mental health discipline from a regionally accredited institution.
- Obtain Clinical Membership in AAMFT. (An applicant who is not an AAMFT Clinical Member is required to apply and meet the current requirements for Clinical Membership.)

Having met the prerequisites, the prospective supervisor-in-training submits the following:

Training Contract

A non-refundable $50 processing fee in U.S. dollars.

An applicant is an official supervisor-in-training only after receiving a letter from the AAMFT documenting that the Training Contract has been accepted

After being accepted as a supervisor-in-training, the applicant completes the following training program:

- Provides at least 180 hours of MFT supervision over a minimum period of eighteen months and a maximum of two years.
- Receives at least 36 hours of supervision-of-supervision from an AAMFT Approved Supervisor within eighteen months to two years. An applicant may be supervised by no more than two Approved Supervisors, each of whom must provide a minimum of eighteen hours of supervision-of-supervision. Supervision-of-supervisions should focus on live or taped sessions, and may include no more than two supervisors-in-training. Supervision must be of MFT cases. During the supervision-of-supervision period, the applicant must supervise at least two supervisees on a regular schedule (approximately every two weeks) in individual supervision for a minimum of nine months each.
- Completes a one-semester graduate course in MFT supervision (at least 30 contact hours) or the equivalent. This course may be taken prior to or during the training period. However, the course must have been taken no less than five years before the time the final application is submitted.
- By the time of application, the applicant must have provided at least 3,000 hours of post-master's MFT over a minimum of three years.

COAMFTE-Accredited Doctoral Track Requirements

The COAMFTE-Accredited Doctoral Track is for those who are currently enrolled in doctoral programs accredited by the AAMFT Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE).

STEPS:

At the time of filing a Training Contract, the prospective supervisor-in-training must have:

- Provided 500 supervised hours in the clinical practice of MFT (experience obtained in a COAMFTE-accredited master's program may be counted toward these hours.)
- Current enrollment in a COAMFTE-accredited doctoral program that includes a supervision course.

Having met the pre-requisites, the prospective supervisor-in-training submits the following:

Training Contract

A non-refundable $50 processing fee in U.S. dollars

An applicant is an official supervisor-in-training only after receiving a letter from the AAMFT documenting that the Training Contract has been accepted

After being accepted as a supervisor-in-training, the applicant completes the following training programs:

- Provides at least 180 hours of MFT supervision over a minimum period of eighteen months and a maximum of five years. Applicants under this track may supervise other doctoral students to accumulate supervision experience. However, the following conditions must be met: (1) the supervisor-in-training is supervised by an Approved Supervisor during this period (2) the supervisor-in-training is an advanced doctoral student and the supervised doctoral student is relatively less experienced in MFT (3) the supervisor is not involved in determining grades for the supervised doctoral student.
- Receives at least 36 hours of supervision-of-supervision from an AAMFT Approved Supervisor. Half of these hours should be obtained while enrolled in the practicum course in MFT supervision. The remaining 18 hours must be obtained subsequently, within a period of nine months to five years from the beginning of the course.
- Supervision-of-supervision should focus on live or taped session, and my include no more than two supervisors-in-training. Supervision must be of MFT cases. During the supervision-of-supervision period, applicants must supervise at least two supervisees on a regular schedule (approximately every two weeks) in individual supervision for a minimum of nine months each.

- Completes a one-semester graduate course in MFT supervision (at least 30 contact hours).
- Graduates from a COAMFTE-accredited doctoral program.
- By the time of application, an applicant must have provided at least 2,000 hours of client contact in the practice of MFT over a minimum of three years. Of this total, up to 500 hours of supervisory experience may be substituted for clinical experience.

Advanced Track Requirements

The Advanced Track is reserved for applicants with extensive experience in MFT, teaching and supervision.

STEPS:

At the time of filing a Training Contract, the supervisor-in-training must have:

- Provided a minimum of 12 years and 4,000 hours of post-master's MFT.
- Provided a minimum of eight years and 500 hours in MFT teaching.
- Provided a minimum of eight years and 300 hours in the supervision of MFT.
- A qualifying graduate degree in a mental health discipline from a regionally accredited institution.
- Obtained Clinical Membership in AAMFT. (An applicant who is not an AAMFT Clinical Member is required to apply and meet the current requirements for Clinical Membership.

Having met the pre-requisites, the prospective supervisor-in-training submits the following:

- Training Contract
- A non-refundable $50 processing fee in U.S. dollars.

An applicant is an official supervisor-in-training only after receiving a letter from the AAMFT documenting that the Training Contract has been accepted

After being accepted as a supervisor-in-training, the applicant completes the following training program:

- Receives at least 18 hours of supervision-of-supervision within three months to two years with an AAMFT
- This supervision-of-supervision may take place individually or in a group no larger than four senior colleagues plus the Approved Supervisor leading the group.
- Applicants must be actively supervising a marriage and family therapist during the period they are receiving the 18 hours of supervision-of-supervision with an AAMFT Approved Supervisor.
- If an applicant in a country other than the U.S. or Canada, meets all pre-requisites for the Advanced Track, and if there is not an AAMFT Approved Supervisor in his or her geographical area, the applicant may petition the Standards Committee

to waive the 18 hours of supervision-of-supervision. All other requirements remain the same.

After completing the training program on any of the above tracks, the supervisor-in-training submits the application:

- Within one year from the conclusion of supervision-of-supervision in accordance with the dates on the original Training Contract. An applicant who exceeds this time limit may no longer be identified as a supervisor-in-training and must petition the Standards Committee in writing to request an extension.
- The applicant must have obtained at least 18 hours of supervision-of-supervision within the two years prior to submission of the application.
- The supervision course may not be older than 5 years at the time of submission of the final application.
- All application materials must be dated within six months prior to application. All written materials must follow guidelines that are current at the time of application.
- A non-refundable application fee of $150 in U.S. dollars.
- All of the following :
  Completed Final Application form
  Completed Approved Supervisor Rating Sheet
  Supervision-of-Supervision Report form(s)
  Supervision Course Report/verification of completion if pre-approved course(Standard & Doctoral Track applicants only)
  Description of supervision-of-supervision experience
  Supervision philosophy statement
  Supervision case study
  Official Transcript verifying receipt of doctoral degree(Doctoral Track only)
  Clinical membership offer(Doctoral Track only)

APPENDIX B

E-MAIL TO PARTICIPANTS

First Round of Data Collection

Initial Contact

Subject: Clinical Supervisor Survey

The role of AAMFT Approved Clinical Supervisors is primary in the training of MFT's, yet research regarding supervisors is minimal. To add to that literature I am conducting a research study exploring how clinical supervisors conceptualize cases.

Within the next few days you will be receiving a very, very brief 2 question survey at this same e-mail address. I would greatly appreciate it if you could take a few moments to complete it. You will not be providing any personally identifying information, and it will take less than 5 minutes to complete

If you have any questions, feel free to contact me (Kathleen Adams), or Professor Harvey Joanning at 515-294-5215, or by e-mail at joanning@iastate.edu.

Thank you in advance for your time.

Sincerely,

Kathleen M. Adams
Ph.D. Candidate
Human Development and Family Studies
Iowa State University
adamsk@iastate.edu
515-232-2376

Second Contact

Subject: Clinical Supervisor Survey

A few days ago I let you know that I would be sending you a very brief survey about how AAMFT Approved Clinical Supervisors conceptualize cases. That survey is below.

This will take less than 5 minutes to complete and your responses will be confidential. Of course, you are under no obligation to complete the survey, but I do hope you will.

There are three ways to return the survey:

1. Click the "Reply" command on your computer, enter your responses, and click "Send."

2. Copy and past the questions into a new e-mail addressed to adamskath@aol.com, type your responses and send.

3. Print this message, write your responses, and mail to:
Kathleen M. Adams
1016 Roosevelt Ave
Ames, Iowa 50010

If you have any questions, please contact me (Kathleen Adams) at 515-232-2376 or at adamskath@aol.com. Or you may contact Professor Harvey Joanning at 515-294-5215 or at joanning@iastate.edu.

Again, thank you for your time.

Sincerely,

Kathleen M. Adams
Ph.D. Candidate
Human Development and Family Studies
Iowa State University
adamsk@iastate.edu
adamskath@aol.com

Third Contact

Subject: Clinical Supervisor Survey

At the end of last week you received a very brief survey via e-mail about how AAMFT Approved Clinical Supervisors conceptualize cases. I've not yet received a completed survey from you, and hope you will be able to take a few minutes to complete one. Because I have invited a small, but nationally representative group of Approved Clinical Supervisors to participate, your responses are important.

In case the previous survey has been deleted from your e-mail, another is provided below. Directions for returning the survey follow. The survey will take less than 5 minutes to complete and your responses will be confidential. Of course, you are under no obligation to participate, but I do hope you will.

If you have any questions, please contact me (Kathleen Adams) at 515-232-2376, or at adamskath@aol.com. Or you may contact Professor Harvey Joanning at 515-294-5215, or at joanning@iastate.edu.

Again, thank you for your time.

Sincerely,

Kathleen M. Adams
Ph.D. Candidate
Human Development and Family Studies
Iowa State University
adamsk@iastate.edu
adamskath@aol.com

Fourth Contact

Subject: Please Advise

The response rate to the Clinical Supervisor survey has been very low. It would really help if I could learn why. Would you be kind enough to take a minute to let me know if you have chosen not to respond because you have concerns about the research? or methodology? or for some other reason?

If you would still consider completing a survey, that would be wonderful and another is provided below. The survey generally takes less than 5 minutes to complete, your responses will be confidential, and of course, you are under no obligation to participate. Directions for returning the survey follow. Research results will be e-mailed to you in March.

If you have any questions, please contact me (Kathleen Adams) at 515-232-2376, or at adamskath@aol.com. Or you may contact Professor Harvey Joanning at 515-294-5215, or at joanning@iastate.edu.

With appreciation for your time,

Kathleen M. Adams
Ph.D. Candidate
Human Development and Family Studies
Iowa State University
adamsk@iastate.edu
adamskath@aol.com

Fifth Contact

Subject: Clinical Supervisor Survey

You were invited to complete a survey for a research study I am doing with a sample of AAMFT Approved Supervisors. The preliminary results of that study are now available at http://www.public.iastate.edu/~adamsk/homepage.html. Please consider visiting the site, regardless of whether or not you chose to complete the survey.

All too often the researcher and the "researched" are distanced from each other, just as researchers and clinicians often are. Please consider posting your reactions to the study design and results, reading the comments of others, and engaging with me in what I anticipate will be rich discussion on the discussion board at the site. You may post comments anonymously, or you may identify yourself. Of course, you are under absolutely no obligation to visit the site or to post comments, but I hope you will. While I am using a counter to track how many visits the site receives, no identifying information about you will be available to me. Your confidentiality is assured.

I will be relying strongly on your comments when I document the final study results for my dissertation. You can be certain, however, that while quotes may be used, I will not identify you by name even if you have chosen to identify yourself on the discussion board.

These research procedures have been approved by Human Subjects Review at Iowa State University. If you have any questions, you may contact me, (Kathleen) at adamskath@aol.com, or at 515-232-2376. Or, you may contact Professor Harv Joanning, joanning@iastate.edu, or at 515-294-5215.

With my sincere appreciation for your time and consideration,

Kathleen M. Adams

Ph.D. Candidate
Human Development and Family Studies
Iowa State University
adamsk@iastate.edu

Second Round of Data Collection

Initial Contact

Subject: Clinical Supervisor Survey

I am writing to you to ask if you would be so kind as to take a few minutes to help with a research study I am doing that explores how clinical supervisors conceptualize cases.

Within the next day or so you will be receiving a brief questionnaire at this same e-mail address. It will include a short case vignette followed by the questions, "What is going on in this family?" and "How would you intervene?" I would greatly appreciate it if you could take a few moments to complete it. Others who participated have reported that it has taken anywhere from 2 to 20 minutes to complete. You will not be providing any personally identifying information and your responses will be confidential.

This research project has been approved by the Human Subjects Review committee at Iowa State University, and study results will be e-mailed to you later this month. If you have any questions, please contact me (Kathleen Adams) at adamskath@aol.com, or at 515-232-2376; or contact Professor Harvey Joanning at 515-294-5215, or at joanning@iastate.edu.

Thank you in advance for your time and consideration.

With appreciation,

Kathleen M. Adams, MS, MFT
Ph.D. Candidate
Human Development and Family Studies
Iowa State University
adamskath@aol.com
515-232-2376

Second Contact:

Subject: Clinical Supervisor Survey

Below is the brief questionnaire I wrote to you about in an earlier e-mail. It is part of a study I am doing exploring how clinical supervisors conceptualize cases. If you would be so kind as to take a few minutes to read the case vignette and complete the two questions following it, it would be of great help to me. Directions for returning it follow.

Others who participated have reported that it has taken anywhere from 2 to 20 minutes to complete. You will not be providing any personally identifying information and your responses will be confidential. Of course, you are under no obligation to complete the survey, but I do hope you will. Study results will be e-mailed to you later this month.

This research project has been approved by the Human Subjects Review committee at Iowa State University. If you have any questions, please contact me (Kathleen Adams) at adamskath@aol.com, or at 515-232-2376; or contact Professor Harvey Joanning at 515-294-5215, or at joanning@iastate.edu.

Again, thank you for your time and consideration.

With appreciation,

Kathleen M. Adams
Ph.D. Candidate
Human Development and Family Studies
Iowa State University
adamsk@iastate.edu
adamskath@aol.com

Third Contact

Subject: Clinical Supervisor Survey

At the end of last week you received a very brief survey via e-mail about how AAMFT Approved Clinical Supervisors conceptualize cases. I've not yet received a completed survey from you, and hope you will be able to take a few minutes to complete one. Because I have invited a small, but nationally representative group of Approved Clinical Supervisors to participate, your responses are important.

In case the previous survey has been deleted from your e-mail, another is provided below. Directions for returning the survey follow. The survey will take less than 5 minutes to complete and your responses will be confidential. Of course, you are under no obligation to participate, but I do hope you will.

If you have any questions, please contact me (Kathleen Adams) at 515-232-2376, or at adamskath@aol.com. Or you may contact Professor Harvey Joanning at 515-294-5215, or at joanning@iastate.edu.

Again, thank you for your time.

Sincerely,

Kathleen M. Adams
Ph.D. Candidate
Human Development and Family Studies
Iowa State University
adamsk@iastate.edu
adamskath@aol.com

Fourth Contact

Subject: Please Advise

The response rate to the Clinical Supervisor survey has been very low. It would really help if I could learn why. If you have completed and returned a survey, let me again thank you. If you have not, would you be kind enough to take a minute to let me know if you have chosen not to respond because you have concerns about the research? or methodology? or for some other reason?

If you would still consider completing a survey, that would be wonderful and another is provided below. The survey generally takes less than 5 minutes to complete, your responses will be confidential, and of course, you are under no obligation to participate. Directions for returning the survey follow. Research results will be e-mailed to you in March.

If you have any questions, please contact me (Kathleen Adams) at 515-232-2376, or at adamskath@aol.com. Or you may contact Professor Harvey Joanning at 515-294-5215, or at joanning@iastate.edu.

With appreciation for your time,

Kathleen M. Adams
Ph.D. Candidate
Human Development and Family Studies
Iowa State University
adamsk@iastate.edu
adamskath@aol.com

Fifth Contact

Subject: Clinical Supervisor Study Results

You were invited to complete a survey for a research study I am doing with a sample of AAMFT Approved Supervisors. The preliminary results of that study are now available at http://www.public.iastate.edu/~adamsk/homepage.html. Please consider visiting the site, regardless of whether or not you chose to complete the survey.

All too often the researcher and the "researched" are distanced from each other, just as researchers and clinicians often are. Please consider posting your reactions to the study design and results, reading the comments of others, and engaging with me in what I anticipate will be rich discussion on the discussion board at the site. You may post comments anonymously, or you may identify yourself. Of course, you are under absolutely no obligation to visit the site or to post comments, but I hope you will. While I am using a counter to track how many visits the site receives, no identifying information about you will be available to me. Your confidentiality is assured.

I will be relying strongly on your comments when I document the final study results for my dissertation. You can be certain, however, that while quotes may be used, I will not identify you by name even if you have chosen to identify yourself on the discussion board.

These research procedures have been approved by Human Subjects Review at Iowa State University. If you have any questions, you may contact me, (Kathleen) at adamskath@aol.com, or at 515-232-2376. Or, you may contact Professor Harv Joanning, joanning@iastate.edu, or at 515-294-5215.

With my sincere appreciation for your time and consideration,

Kathleen M. Adams
Ph.D. Candidate
Human Development and Family Studies
Iowa State University
adamsk@iastate.edu

APPENDIX C

DATA COLLECTION INSTRUMENTS

Please read the following case vignette and respond to the questions that follow.

Male perpetrator version:

Carol and James have been married 10 years. They have two children, Dana, 9, and Tracy, 7. James is employed as a foreman in a concrete manufacturing plant. Carol also is employed. James is upset because on several occasions Carol did not return home from work until two or three in the morning and did not explain her whereabouts to him. He acknowledges privately to the therapist that the afternoon prior to the session he had seen her in a bar with a man. Carol tells the therapist privately that she has made efforts to dissolve the marriage and to seek a protection order against her husband because he has repeatedly been physically violent with her and the kids, and on the day prior, he grabbed her and threw her on the floor in a violent manner and struck her. The family had made plans to go shopping, roller-skating and out to dinner after the session.

1. What is going on in this family?
2. How would you intervene?
3. Anything else that might be helpful for this research?

Gender: Race:

Female perpetrator version:

Carol and James have been married 10 years. They have two children, Dana, 9, and Tracy, 7. James is employed as a foreman in a concrete manufacturing plant. Carol also is employed. Carol is upset because on several occasions James did not return home from work until two or three in the morning and did not explain his whereabouts to her. She acknowledges privately to the therapist that the afternoon prior to the session she had seen him in a bar with a woman. James tells the therapist privately that he has made efforts to dissolve the marriage and to seek a protection order against his wife because she has repeatedly been physically violent with him and the kids, and on the day prior, she grabbed him and threw him on the floor in a violent manner and struck him. The family had made plans to go shopping, roller-skating and out to dinner after the session.

1. What is going on in this family?
2. How would you intervene?
3. Anything else that might be helpful for this research?

Gender: Race:

APPENDIX D

ALL DATA WITH CODES

Codes

Gr = Group
1 = Female perp, program directors
2 = Male perp, program directors
3 = Female perp, non directors
4 = Male perp, non directors
5 = Male perp, Iowa supervisors

Gn = Gender
1 = Female
2 = Male
3 = Information not provided

R = Race
1 = Caucasian
2 = Black or African American
3 = Information not provided
4 = Creole
5 = Latino/a

VA = Is the violence addressed?
1 = yes
2 = no

AA = Is agency addressed?
1 = yes
2 = no

J, C, B, Ch = James, Carol, Both, Children
# of references to each

S = Is safety addressed?
1 = yes
2 = no

RCA = Is reporting the child abuse addressed?
1 = yes
2 = no

Al = Is alcohol/substance abuse addressed?
1 = yes
2 = no

G = Is immediacy addressed?
1 = yes
2 = no

T = What therapeutic modality is addressed?
0 = none
1 = individual
2 = couples
3 = individual and couples
4 = safety first, then individual and couples

Th = Theme
1 = violence, battering
2 = abuse
3 = conflict
4 = anger
5 = power struggle
6 = control issue
7 = question truth, therp triang.
8 = non conflict other
9 = don't know, not enough info
10 = aggression
11 = destructive behavior

APPENDIX D

ALL DATA WITH CODES

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9 = don't know, not enough info
10 = aggression
11 = destructive behavior

Female Perpetrator Vignette

Program Directors

ID	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	AI	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	AI	G	T
11	2	1	Wife in her unfortunate way seems desperate to hold onto him Why?		8		1	2						Separate interviews (a) to minimize provocations of further violence, but mostly (b) to try for private and genuine statements of what these people really want	x	9						1				X
			I hear nothing here of the pitiful guilt that often seems to follow violent outbursts of husbands (for a time), and wonder why he failed in getting a restraining order		8		2							If we get that, we are halfway home to a resolution		8										
			Where are the forces of law and order (at least for the kids)?		8									Someone needs to see the kids, who may or may not add reality to the picture (since they are as likely to be biased as anyone), but they are surely at risk		8							3			
			The husband claims to want out, but sails along on business as usual		8		1																			
			Perhaps he too has wants that are not quite what he tells us, her, or himself (as in staying married with a little wandering now and then)		8		3	1																		
			Then of course there is the possibility that some of the private talk was private because it would be denied by the other spouse, and might actually be false		7				1																	
			Of course, we can count on the wife claiming that she gently pushed husband out of her face, whereon he tripped on something and fell dramatically, but this adds nothing to real information about the truth		7		2	3																		
			Was husband really with other woman?		8		1																			
			If so, was it in a place where he could reasonably expect to be seen?				1																			
11				0	12	2	11	6	1	0	2	2	2		1		2	2	2	2	2	1	3	2	2	1

ID	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	AI	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	AI	G	T
12	2	1	Severe marital conflict with the therapist triangulated into their communication		x									I would try to get the therapist to bring the accusations more out in the open if possible and get out of the middle of the communication.		7											
			I would be concerned about the kids and the husband but I also would want to make sure that as the therapist I was getting more direct information concerning the abuse accusations than I have here		7		1			1				I would also like to know if a protection order has been issued and what is the status of that order.												
12				2	7	2	1	0	0	1	2	2	2		2	7	2	2	2	0	0	0	0	2	2	2

ID	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
13	2	1	The family lacks clear organization and is a mess											in line with what the therapeutic contract was												
13				2	8	2	0	0	0	0	2	2	2		2	8	2	2	2	0	0	0	0	2	2	2

ID	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
14	1	1	James appears to be abused by his wife		2		2	1						I would be very concerned about the apparently escalating tension and violence in this household.	x	1									1	
			However, another possibility is that both are trying to develop a coalition with the therapist against the partner		7				1					I would give James a hotline number and talk with him about safety planning		1		1		2						
			This may be part of a future custody battle											I would talk with Carol about how she responds to James' apparent infidelity and see if she also reports that she has been violent with him.	x	1	1			2	4					
			But, until I gain more information, I take seriously the possibility that Carol has been physically abusive with James and the potential danger of the ongoing possibility of marital infidelity by James, anger by Carol and violence.	1	1	x	2	2						I would also see if she reports that he has been violent.	x	1	1			1	1					
														I would express my concern with both of them that this appears to be a potentially dangerous living situation.		1						1				
														I would determine what they hope to have as the outcome of therapy.								1				
														If they both want to save the marriage and both admit to his or both person's violence I would require that a "no violence" contract be signed before I would continue treatment.	x	1	3			1		3				
														If she does not admit to violence, and he continues to report that she is violent, I would not continue conjoint therapy and would encourage him to take steps to maintain his safety.	x	1	1	1		3	2	1				4
														If I were to work with both of them and both of them wanted to maintain the marriage, I would also talk with James about his apparent infidelity, but I see the violence as the primary issue	x					1		2				
14				1	1	0	4	3	1	0	2	2	2		1	1	6	2	0	10	7	6	0	0	1	4

ID	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	AI	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	AI	G	T
15	1	1	alleged violence, child abuse	x	1					1				meet today with husband alone and discuss boundaries of confidentiality-eg re potential child abuse and need for reporting of same		1		x	x	1			1			x
			marital distance/conflict		3									meet today with wife alone and discuss boundaries of confidentiality-eg vocalizing increased marital distance and encourage her to discuss it in joint session with husband						1	2					x
			question infidelity											meet today with couple to discuss violence and child abuse and safety plan for all family members	x	1		x				1	1			x
			triangulation of therapist/secrets		7									depending on outcome of above meetings decide who to see next and what way to intervene												
				1	1	2	0	0	0	1	2	2	2		1	1	2	1	1	2	2	1	2	2	2	3

ID	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
16	2	1	First, I do not see this as a family case, but rather as a marital case											I do not know if the husband has been violent with the wife also, or if he attacked her first and she defended herself... so based on the information I have, I would treat it like a traditional violence case (only with the sexes switched) and	x	1	x			2	3					
			There is too little information to tell, but, based on the information, everything is about the marital relationship.											1. help the husband find a safe place the children and him to go if the violence continues	x	1		x		2			1			
			I would first have to view this as an abuse case because of the level of the violence described	x	2									2. Develop a "no violence contract" with the couple	x	1						1				
			Even if it is systemic, this level of violence is unacceptable and must be stopped	x	1									3. Help the wife and husband develop a plan to notice the first signs of violence and each have a way to terminate the interchange and have a place to cool off.	x	1	x			1	1	1				
														4. Help the wife learn to control her anger and aggression.	x	4	x				2					
														5. Help the husband to learn to stand up to her, take care of himself, and/or possibly leave the marriage						2	1					
														6. Incorporate other aspects of the marriage, and the potential affair, for marital discussion.												
														7. Help the couple communicate more effectively and problem solve more effectively once the abuse starts to get under control.		2	x					1				
				1	1	2	2	0	0	0	0	2	2		1	1	1	2	2	7	7	3	1	2	2	2
ID	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
17	2	1	I could not ascertain from the little information given what is going on in this family.											I would not know how I would intervene without more information.												
			I would do more assessment, following through on obtaining more information regarding the violence occuring as well as the possibility of infidelity.	x										I would certainly assess the risk of violence for the children as well as adults and proceed accordingly depending on the risk.	x							1	1			
				1	1	2	0	0	0	0	2	2	0		1	1	2	2	2	0	0	1	1	2	2	2

Male Perpetrator Vignette

Program Directors

ID	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	AI	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	AI	G	T
21	2	1	This family is dominated by issues of domestic violence, a complementary relationship that leads probably into a schizmogenic crisis, and underlying issues of male dominance	x			1							Honor the protective order, if its in place													
			Conceptually speaking, the ambivalence toward the relationship is clear in terms of who is and who is not committed to the marriage											Negotiate with the judge to see the couple and family								1				x
			The symmetrically is exacerbated by unexplained absences, physical violence, etc	x										Secure a no violence contract and a no-escalation agreement												
			An apparent contradiction exists between dissolution of the marriage and the overt ways in which togetherness is indicated, ie, shopping, roller skating, and dinner											Negotiate a no-contact contract with her, if indeed she is seeing another man							1					
			This likely gives the kids in the family the illusion of togetherness despite whatever they know or don't know about the violence and the protective order.	x						2				Assess the potential for alcohol and an affair to be perturbing phenomena										x		
														Negotiate the ambivalence with the couple								1				
														Diffuse the larger context and attend to the kids and their roles in the family									1			
21				1	1	2	1	0	0	2	2	2	2		2	1	2	0	0	0	1	2	1	1	2	3
ID	Gn	R	What's happening in this family?	VA		AA	J	C	B	Ch	AI	G	T	How would you intervene?	VA		AA	S	RCA	J	C	B	Ch	AI	G	T
22	2	1	Instead of family, I want to comment on what's going on in the therapeutic system		7									Need to shortcircuit their current organization and operation as it impacts their exchange of information (communication) while alerting her to area resources addressing domestic violence	x	x					1	2				
			Appears to me the therapist is at great risk for (if not already in) recreating what's already happening in this family,		7									and assisting her in developing a safety plan for the immediate future		1		1			1				1	
			i.e., indirect and fragmented communication that simply confounds an already problematic situation		7																						
			Rather than the therapist impacting the relational system he/she is apparently being more significantly impacted by them in a fashion that results in mirroring their operation		7																						
22				2	1	2	0	0	0	0	2	2	2		1		2	1	0	0	2	2	0	2	1	0

ID	Gn	R	What's happening in this family?	VA		AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA		AA	S	RCA	J	C	B	Ch	Al	G	T
23			Domestic violence, breakdown of the marital subsystem	x										Immediate safety plans for both				1				1				
														No violence contract	x											
														Practice of violence control strategies	x											
														Possible DV training for husband	x					1						
														See children to deal with violence issues	x							1				
														Separate sessions for both W & H until safety is clear				1				1				x
														After that conjoint treatment if the couple is still together and wishes to work toward a successful marriage								1				x
23				1	1	2	0	0	0	0	2	2	2		1	1	2	2	0	1	0	3	0	2	2	4
ID	Gn	R	What's happening in this family?	VA		AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA		AA	S	RCA	J	C	B	Ch	Al	G	T
24	1	1	Too little information to make conclusions, but (a) clear suspicion of domestic violence, (b) possible deception by female to justify extramarital affair, (c) possible triangulation of therapist in marital conflict	x				1						Establish safety plan with female; maintain individual sessions while confirming threat of violence; assess male's potential for criminality/"cobra" qualities (Jacobson/Gottman);	x			1		1	1						x
														assess possibility of intermittent conjoint sessions to assess couple interaction depending on above info								1					x
24				1	1	2	0	1	0	0	2	2	2		1	1	2	1	0	1	1	1	0	2	2	4
ID	Gn	R	What's happening in this family?	VA		AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA		AA	S	RCA	J	C	B	Ch	Al	G	T
25	1	1	There is grave concern about the domestic violence in this home	x										I would address the safety issue that are imminent				1							x	
			There are legal and ethical implications for the welfare of the children and the mother.					1		1				Since the police have been notified, it would be appropriate to put then on the alert about the situation (i.e. phone call from the office)												x	
			The escalation is clear and I would be concerned about the immediate safety of all members after leaving the session.									x		Separation needs to be arranged to obviate further potential of danger and harm												x	
														A shelter situation for the family or a place for husband to separate himself from the family would be important to establish.						2							
														Referral to domestic violence clinic in the community	x												
														The immediate concern is for immediate safety.				1							x	
														I would be try to help everyone in the family (including the husband) understand these precautions are in his best interest of all family members.						1							
														Family plans for after the session would have to be cancelled											x	
														I would be obligated to contact the social service protection agency about the risk the children are in and would let the family know about the report					1				1			
														At this point, the seriousness of the situation needs to be addressed with as much assertion and structure as possible											x	
25				1	1	2	0	1	0	1	2	1	2		1	1	2	2	1	3	0	0	1	2	1	0

ID	Gn	R	What's happening in this family?	VA		AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA		AA	S	RCA	J	C	B	Ch	Al	G	T
28	2	1	We have, by report, a husband who recognizes his wife's distancing and possible extra marital relationship of some sort				2	1						1 Gather information - The first intervention would have to be to learn more about the violence to the children	x								1			
			We have a wife who reports a violent husband, perhaps with a full cycle of violence	x		x	1	1						If it is actual violence, it mandates a report in this state	x				1							
			The relation between his observation of extra-marital attachment and his violence is as yet unspecified	x		x	2							I would like to know more to assess the immediacy of danger to the children as they go skating				1					1		x	
			We have a therapist who is being triangled by 'confidences'.											The result of that inquiry would influence the need for immediate intervention				1							x	
			We have an as yet unspecified report of 'violence' toward the children	x										If it were required, the staging of it would have to be wisely planned				1							x	
			Speculating, I anticipate the probability of an enmeshed system with rigid external boundaries											I would like to know more about the violence toward the wife	x						1					
			I anticipate the probability of developmental damage and rigid schemas for both spouses with a possibility of violence toward the husband and perhaps the wife as they grew.				1	1	1					It is a criminal act of assault in this state	x											
			I anticipate the probability of weak communication skills and impulsive reactivity on the part of both spouses						1					Its frequency and severity would influence the immediacy of her need for protection	x			1			1				x	
			The probability of triangled children seems high and their gender is as yet unspecified							1				As an adult she must make her own decisions, but may lack knowledge of options							1					
														I would like to learn more about the immediacy of danger to the wife and what sort of resources are immediately available for her protection if there is ongoing danger to her or to the kids.	x			1			3				x	
														I would like to know more about him in order to assess whether we have a violent response to assumed infidelity/disloyalty or one more act in a pattern of violence.	x					1						
														2. Intervene to protect the children, if necessary.				1					1			
														3. Promote a stable, safe situation for the wife, the specifics depending on what is learned.				1			1					
														4. Assess the husband to determine his readiness to deal with tension in a non-violent way.	x		x			1						
														5. Depending on the outcomes of 1-4, work toward a different family relationship with less historical reactivity and with different ways of both developing intimacy and managing conflict/tension.								1				
28				1	1	1	6	3	2	1	2	2	2		1	1	1	4	0	2	7	1	3	2	1	0

ID	Gn	R	What's happening in this family?	VA	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	AA	S	RCA	J	C	B	Ch	Al	G	T
27	2	1	We certainly have a situation where some level of battering is going on that places Carol and the children at risk.	x			1		1				In the short run, only concurrent sessions.											x
			We don't know yet whether that has preceded (it probably has) the behavior that looks like her seeking other relationships (though the latter may be the control-justifying fantasy of the husband).	x		1	1						I'd ascertain from her the history of the violence, her safety plan if any (create one if none exists), inquire into other resources she may have to augment safety and support.	x			1		3					
													With him I'd inquire into the history of his complaints about her staying out and being seen with other men,					2	1					
													I'd inquire about what he believes is right and required of a husband in such situations,					2						
													and if he says anything that acknowledges that he has been violent with her I'd ask about the history of that, how it stops when it does, who stops it, and about his history of violence in other situations.	x		x			3	1				
													that would enable me to assess to what extent working with him around anger management is an available and necessary option.					1						
27				1	1	2	1	2	0	1	2	2	2	1	1	1	1	0	8	5	0	0	2	2	1
ID	Gn	R	What's happening in this family?	VA	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	AA	B	RCA	J	C	B	Ch	Al	G	T
28	1	1	I am not sure from the information given but if there is any chance of violence, it needs to be dealt with first.	x									I would share my concerns about safety for the WHOLE family--if there has been physical abuse to the children it should have already been reported but if not I would report it with both parent's present.	x		1	1			1	1			
			Since I had been told privately by the wife, I would have already suggested that without a safety plan, marital work is not likely to be helpful--even dangerous.	x			1					x	I would risk the case to get each of them and their children the resources and support to minimize the risk of another act of violence.	x		1				2	1			
			I would ask her how she wanted to proceed to get the issue of safety on the table and counsel her that she has a right to keep herself and the children safe regardless of other issues.	x			4						I would stay with the case until each family member agreed to some personal safety plan until more extensive work could be done.			1				1				
			I would have given her shelter names and advocacy organizations so she could make the necessary moves for safety.	x			2																	
			I would attempt to discover his support system--how he will be safe from his violence if she leaves.	x	x	3	1																	
			I would worry about their family activities turning violent.	x																				
28				1	1	3	8	0	0	2	2	1		1	1	2	3	1	0	0	4	2	2	2	0

ID	Gn	R	What's happening in this family?	VA		AA	J	C	B	Ch	AI	G	T	How would you intervene?	VA		AA	S	RCA	J	C	B	Ch	AI	G	T
29	1	1	Safety issues first on this one											Deal with the safety issues first				1								
			Assessing for possible violence, need to protect the children, possibly from both parents, father has been accused of violence but mother is staying out late at night when her children might need protection too	x		x	1	2	1	1				If there is battering and violence toward the children, report the violence as we are mandated to do	x				1				1			
			Secret keeping, not unusual in violent cases, but also some confusion here about who/what is telling the truth here and what secrets are going on	x										Meet individually with each parent until there is a clear understanding of who is vulnerable to what, what the risks are and the potential for greater harm if there is couple therapy.				1				1				x
			Trust and communication issues, gender issues, power and control issues, all interlwined on this case											Meet with the children with each parent present, possibly family or couple therapy depending on what arises								1	1			
			In terms of the therapist, being certain that the therapist is safe, not pulled into the system, able to do whatever needs to be done	x										Need for establishing safety guidelines and contracts for non-violence	x			1								
														Possibly send the father to anger management groups if the therapist sees a need						1						
														Find out what the mother is up to late at night							1					
														Ascertain whether there is potential to save the marriage or not.												
28				1	1	1	1	2	1	1	2	2	2		1	1	2	3	1	1	1	2	2	2	2	1
ID	Gn	R	What's happening in this family?	VA		AA	J	C	B	Ch	AI	G	T	How would you intervene?	VA		AA	S	RCA	J	C	B	Ch	AI	G	T
210	2	1	Domestic violence cycle, poor communication	x										Safety issues first -- regarding on-going violence and potential of violent reaction to disclosure Carol made.	x			1			1					
														Mandated reporting of suspected abuse toward children (arming them with referral sources in the even that they were unwilling to continue with me after the reporting)					1			1	1			
210				1	1	2	0	0	0	0	2	2	2		1	1	2	1	1	0	1	1	1	2	2	0

Female Perpetrator Vignette

ID	Gn	R	What's happening in this family?	Not Directors VA	Th	AA	J	C	B	Ch	AI	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	AI	G	T
31	2	1	Possibly domestic violence on the part of the woman	x	1	x		1						I would interview the woman privately and question her about conflict in the family		3					2						x
			The immediate issue is whether there is in fact violence taking place against the children and husband (as the husband alleges)	x	1		2			1				I would directly question her to determine if her husband has been physically violent against her and/or the children	x	1					3		1			
			It is possible that a child protective services report would need to be given		1					1				I would then ask if she has also been physically violent against the children and the husband	x	1	x			1			1			
			The women should be treated the same way that a man under these circumstances					1						A child protective services report may need to be initiated (I encourage the parents to file the report with my support)		1			x				1			
			Until the safety issue is dealt with, other issues cannot be addressed		1									I would want to know if mutual violence is taking place	x	1	x					1				
			The status of the protective order may indicate that the family should not/cannot be seen together		1									I would express concern for the wellbeing of the children in both experiencing and witnessing the violence	x	1							1			
														I would determine if a protective order is actually in place		1					1					
														If so, chances are that the couple should not be at the therapist's office together.		1										
														I would make sure that anyone at risk have a safety plan.		1		x								
														If I had determined that violence was in fact taking place, I would have a conversation with the recipient of the violence to determine his/her concern about the lethality of the situation, and perhaps--since they already a bit	x	1								x	
														If there were evidence of violence I would get everyone, kids included to sign a no-violence contract.	x	1						1	1		
														Before they left I would make sure that the possibility of violence after the session was minimized.		1						1			
31				1	1	1	2	2	0	2	2	2	0		1	1	1	0	1	1	6	3	5	2	1	1

ID	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
32			Can't say for sure unless you really get to hear from both with a lot of listening		8				1					Meet with both for one or two weeks, and then see each spouse individually.....								2				x
			Need to place all behaviors into a context with a history, even three generational issues, understanding of losses, and past painful experiences		8									they both need to be willing to work on the issues in the marriage in order to make progress in that area . .		8						1				
			Would help to view their relationship strngths and how it has evolved with some time spent understanding disppointments and positive times.		8				1					..work individually until you can have both ready to work..								2				
			There is some chance the husband is having an affair and that this has provoked the wife into her losing control		8		1	1						.If the husband is involved with another woman,I would ask that he stop seeing her in order to give his marriage his best effort .		8				4						
			However, her violence may be pushing her husband away and making it hard for him to find solutions to their problems	x	1	x	1	2	1					after all he came into therapy with the idea that something could happen, and he will feel best if he gives the marriage his best shot..		8				4						
														If it can't work after a sustained gitted effort, then so be it, he may have a situation that is very tough. .... even then miracles can happen .		8				1						
														I'd become solution focused at some point during therapy...												
32				1	12	1	1	2	1	0	2	2	0		2	8	2	2	2	9	0	5	0	2	2	3
ID	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
33	1	1	First of all it is not clear whether these two people have presented for couples therapy or if they are each seeing the therapist individually.		8				3					First I'd want to assess the level of safety in the family		1		1								
			If they did present as a couple then the significance of the private communication is an important factor in this vignette		8				1					If they were being seen together I'd want to meet with each individually to get more clarity on what is going on in terms of violence, child abuse, substance etc.	x	1						2	1	x		x
			Why the need to communicate this privately?		8									Perhaps it's not safe for them to talk about these things in front of one another.		1						2				x
			To me this means there are alot of family issues, communication problems, denial and triangling		7									I might want to see the kids first assess for child abuse.		1							1			
			These issues are often present with the kinds of obvious issues presented in this vignette substance use, perhaps an alcoholic family system, domestic violence and child abuse	x	x					1	x			If it wasn't a matter of safety I'd like to explore with each of them why they couldn't talk together about these things and set up with them some policy regarding material shared outside of session and confidentiality.				x				4				
			If she is "repeatedly physically violent" toward James and the children then she is the perpetrator.	x	1	x		1		1				If I do assess for dom violence I would talk to him alone about going somewhere safe with the kids and refer her to a batterer's group.	x	1		x		1	1					x
			I suspect there is alot of acting out in this family and underlying attachment problems for each of them individually		8				1					If there is child abuse I would need to report it immediately to DCS.		1			x				1			
			The last line is strange to me		8									I'd educate about the cycle of violence, I'd refer him to AA or detox if he's in fact drinking to excess and her to a psychiatrist for possible meds if she's very depressed or has trouble with affect regulation. (and assess her for substances too)	x	1				2	3			x		
			It conveys a sense that despite the chaos they experience together -they are presenting as though they are about to go do something as 'one big happy family'		8				3					I'd like to talk to them about all of this and get a team of people to help me because I think I'd feel overwhelmed by this family.								1				
			This could mean there is a positive element to their experience together, or, just confirms a sense of denial around the issues they are facing.		8				2					If she's having more of a reactive rage to his alcoholism (not using rage to dominate and control)we'd look at that and maybe send her for anger management		4				1	2					
			This cannot be determined from what is described in the vignette alone		8									Either way, I'd work toward each of them individuating, developing autonomy as there is merging and symbiosis between them that perpetuates the cycle.		8						2				
														I'd also like to find out what their support system is if any								1				
33				1	1	1	0	1	10	2	1	2	0		1	1	2	1	1	3	5	4	0	1	2	1

ID	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
34	1	1	Marital dissatisfaction		8									Make a suspected child abuse report		x			x				1			
			Possible marital conflict		3									Interview each spouse seperately to assess for safety and make plans as appropriate to assure the safety of the children and spouses		1		x				2	1			x
			spousal abuse, child abuse, extramarital affair		2				1	1																
				2	2	2	0	0	1	1	2	2	0		2	2	2	1	1	0	0	2	2	2	2	1
ID	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
35	1	1	Someone may not be telling the truth		7				1					I would talk with the man about protection for he the children.				x		1			1			
														Does he have a safety plan?				x		1						
														Has she ever been violent with the children.		1					1		1			
														I would also want to talk with the wife after this plan was made re: her side of the violence	x	1					2					
														She could be referred to a group for domestic violence.	x	1					1					
														I would also want to know if the man is having an affair and was the secret about the violence an effort to exit the marriage--is he building a case for the divorce?	x	1				2						
														This is a hard one.												
														I think I might refer it.												
35				2	7	2	0	0	1	0	2	2	0		1	1	2	1	2	4	4	0	2	2	2	0
ID	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
36	2	1	There seems to be an inability to process the family anger dynamics openly.		4									Carole and James need to be encouraged to communicate openly about their feelings and wishes.		8						2				
			The therapist seems also to be part of the problem by allowing too any private communications with the therapist thus triangulating the therapist.		7									Mediation is the primary intervention.		8										
			They are evidently not able to talk about issues without acting out their feelings.						2					They need to have an honest confrontation session in a safe and open atmosphere with the therapist enabling them to hear and respond without blaming the other.		8						3				x
			It also seems that they have (not) protected the children from their conflicts and have lived in denial.		3				2	1				They also need to know that the situation may not resolve in continuing the marriage.		8						1				
36				2	8	2	0	0	4	1	2	2	0		2	8	2	x	2	0	0	6	0	2	2	2

ID	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
36	2	1	There seems to be an inability to process the family anger dynamics openly		4									Carole and James need to be encouraged to communicate openly about their feelings and wishes		8						2				
			The therapist seems also to be part of the problem by allowing too any private communications with the therapist thus triangulating the therapist		7									Mediation is the primary intervention		8										
			They are evidently not able to talk about issues without acting out their feelings						2					They need to have an honest confrontation session in a safe and open atmosphere with the therapist enabling them to hear and respond without blaming the other		8						3				x
			It also seems that they have (not) protected the children from their conflicts and have lived in denial		3				2	1				They also need to know that the situation may not resolve in continuing the marriage		8						1				
36				2	8	2	0	0	4	1	2	2	0		2	8	2	x	2	0	0	8	0	2	2	2
ID	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
37	1	1	We don't know what is going on except that they have two kids whose lives are going to be devestated without some intervention		9				1	1				Ensure the safety of the children		1		x					1			
			Husband and wife need to meet together with the therapist not especially and therapist needs to not keep secrets from the couple		7				2				x	Get a friend or relative to live in with them until both parents report no one is in danger of violence	x	1		x				2				
			If the husband is worried about his kids safety why is he staying out all night?		8		3			1				Meet with the couple together, not individually and get mutual goals, get the couple focused on what's the best for the kids, not on their selfish individual needs		8						3	1			x
			Doesn't make alot of sense		8																					
37				2	1	2	3	0	3	2	2	2	2		1	1	2	1	2	0	0	5	2	2	2	2
ID	On	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
38	2	4	COMMUNICATION GAMES. SECRETS. SUBSTANCE ABUSE? GENDER ISSUES. "POWER"		5						x			TO ASK THE QUESTION: WHAT EXACTLY DO YOU WANT FROM THERAPY?		8						1				
			PERHAPS "GASLIGHTING."		8																					
			IF JAMES IS DISSOLVING THE MARRIAGE THEN WHAT DOES HE WANT OF THERAPY - THEN, TO BARGAIN FOR CUSTODY?		8		2																			
38				2	8	2	2	0	0	0	1	2	0		2	8	2	2	2	0	0	1	0	2	2	0
ID	Gn	R	What's happening in this family?	VA		AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA		AA	S	RCA	J	C	B	Ch	Al	G	T
39	1	1	Secrets and therefore unresolved hidden as well as open conflict		7									Direct the couple to talk about subjects they have not talked about: i.e. how they resolve any conflict and then raise the question of physical methods that have been used or are being used to deal with conflict.		3						2				x
														Also raise the question of other people that may be affecting the marriage? friends? other women? other men? in -laws?		8										
														Keep the focus on whether the commitment to work on more realistic ways of resolving conflict is actually agreed to as a way to keep the marriage		8										
														Do both want the marriage?								1				
39				2	8	2	0	0	0	0	2	2	0		2	8	2	2	2	0	0	3	0	2	2	2

ID	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
310	2	1	Physical abuse of children and spouse, patterned violence cycle	x	1					1				Report to social services for abuse of child to start investigation while simultaneously facilitating referral to shelter care for husband and children or networking with relatives with whom husband can live with children.		2			x	2			2			
														referral for legal opinion regarding restraining order												
310				1	1	2	0	0	0	1	2	2	0		1	1	2	2	1	2	0	0	2	2	2	0
ID	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
311	2	1	Communication between the couple is poor.		8				1					Report child abuse		2			x				1			
			Probable substance abuse								x			Assess for homicidality/suicidality	x	1									x	
			Child abuse.		2									Explain confidentiality parameters		8										
			Domestic violence.	x	1									I would hold conjoint meetings with husband and wife and discuss the elephants in the room situation I found myself in where all these secrets had been divulged to me,		7						1				x
			Probable depression in members of the family, anxiety as well		8									but that I was not the one who they should be divulging to.		7						1				
			Issues of trust have been raised.		8									We will work together to bring the truth forward and work from there		7										
			Probable repetition of toxic patterns from childhood.		8									If they are not able to do this work, work individually with each until they have the ego strength and understanding of their own dynamics to enter couples treatment.		8						3				
														Do family of origin work, use object relations theory to examine dynamics they brought into the relationships and the maladaptive ways in which they are coping.		8						2				
														Identify splitting off of good/bad self parts; educate on projections and projective identifications.		8										
														Teach communication skills.		8										
														Hold family meetings and discuss childrens' fears and concerns with parents.		8							1			
														Meet with children individually if necessary.		8							1			
														Refer to MD for possible medication.		8										
														Refer to another battarer's group	x	1	x									
311				1	1	2	0	0	1	0	1	2	0		1	1	1	2	1	0	0	7	3	2	1	2

ID	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al
312	M	1	Really I don't like to speculate from such little information		9									Don't really know without learning from them what is going on experientially in individual and couple sessions		9						1		
			Probably the 7 levels of the mental house (Gottman) are very weak		8									Would have to clarify their goals (individual and joint first), hopes, dreams, communication patterns/styles, values etc first		8				1	1	1		
			(They turn away from each other, have weak love maps, lack admiration and respect, don't know each others dreams, hopes and and aspirations etc)		8				3					Then discover a method to lower the tension level		8								
			This would lead to contempt, criticism, defensiveness and flooding among one or both members of the couple		8				2					Repair efforts, healing rituals, softer start-ups with complaints etc are possibilities		8								
			Most likely they deal with conflict with a harsh start-up, unwillingness to be influenced, lack of compromise and lack of repair efforts (Gottman)		3				1					Eventually I would probably work with forgiveness of self and partner to release the guilt and anger and shift attitudes/beliefs		8						1		
			When conflict develops it leads to attack-attack or attack-withdrawal methods and possibly triangling in a third party		3																			
			Both people are probably hurting/fearful and calling for love in disguised ways		8				1															
			The aggression would have to be dealt with in some way		10																			
			Still without really knowing them all this is just speculation Sad though		9				1															
			Anything that would lower the tension level would be beneficial at first though		8																			
312				0	8	2	0	0	8	0	2	2	0		2	8	2	2	2	1	1	3	0	2

Male Perpetrator Vignette

ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	AI	G	T	How would you intervene?	VA	Th	AA	B	RCA	J	C	B	Ch	AI	G	T
41	2	1	I don't know, based on this information											I guess I'd start with secrets and fear.												
			Based on the story that's tole here I see a fair abount of ambivalence and blaming on the parst of the spouses						1					I'd want to talk asut their preferred ways of communicating if secrecy is counter to that, what the(y) have done and can do to make the need for secrecy and fear go away and see if they want to try to do this as a couple.								4				
			There is a patern of secrest-keeping (Carol at bars with men, James following her, Carol telling the therapist about the protection order in private, James not talking in session about the violence, etc.	x			2	3						or if it's already over, waiting for waiting for Carol's departure.							1					
			On one level the violence can be seen as casting pintence over the family since the consequences of conflict may be stre	x								x		A context of safety would need to be the first order of business.				x								
			The family plans to go shopping and eating can be constructed as an exception to the traumatic story or a superficial skin of normality over the violence that keeps the family secrets.	x																						
41				1	1	2	2	3	1	0	2	1	0		2	0	2	1	2	0	1	4	0	2	2	0
ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	AI	G	T	How would you intervene?	VA	Th	AA	B	RCA	J	C	B	Ch	AI	G	T
42			The first priority for me would be the violence	x										If they showed up as a family, knowing the information that you have given us, I would probably ask to speak to the parent's individually and privately to get more information.								1				
			I would ask more questions regarding the violence toward the wife and the children.	x				1		1				If after obtaining more information and there is a suspicion of child abuse,I would report the child abuse to local social service.					x				1			
			She has already admitted to the violence toward herself.	x				2						If she denies that there is child abuse present, I would still strongly suggest that she seek help with a domestic abuse shelter.							2		1			
			I would also question the violence toward the children.	x						1				I would be hesitant to see the family together knowing that violence exists and there is no way to assure that dad will not retaliate if provoked.	x					1						x
			In WI, I would be mandated to report any violence of children to social service.	x						1				I also wouldn't hesitate to get law enforcement involved if I thought that either the children or the wife were in danger.				x			1		1			
			In the wife's case, I would also suggest that she contact the nearest shelter and have her talk with someone who could provide her with good legal advice regarding protection					4																		
			Husband is probably correct in the suspicion that she is having an affair.				1	1																		
			However, I would see the violence portion of this case as taking precidence over the affair.	x																						
42				1	1	2	1	0	0	3	2	2	0		1	1	1	1	1	1	3	1	3	2	2	1

ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G
43			I would say that Domestic violence is the main issue here and that this appears to take the form of both spousal abuse (battering) and child abuse	x						1				First off since this is a supervision case, I would intervene with my supervisee and have him/her discuss her/his own experience with domestic violence and child abuse as well as infidelity in a relationship and get the supervisee ideas as to intervention	x								1		
			However, I would be interested in getting more information as just like the possibility of infidelity on the part of Carol (out 'til 3am; being seen in a bar with another man, etc)					1						I would insist that safety be a primary concern for everybody in this case and that the supervisee addresses this issue first in seperate and then conjoint sessions				x				1			
			this information was obtained in private and I would want some corroboration in order to proceed further											I would share how if it were my case I would insist that the man get counseling seperately for his violence and the woman be connected with the local domestic violence crisis center	x		x			2	1				
														If the supervisee was not familiar with Domestic violence or the shelter, I would have the supervisee go and visit with the local crisis center and consult with the leaders there	x										
														I would have the supervisee ascertain the level of violence with the children through interviews with the children and if child abuse is suspected then I would insist that a suspected child abuse report be filed with social services (CPS)	x				1				4		
														I would suggest that any marital therapy be put on hold until there has been at least 3 months of no violence.	x										
43				1	1	2	0	1	0	1	2	2	0		1	1	1	1	1	2	1	0	4	2	2
ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G
44	1	2	The couple has a ,destructive, distancer/pursuer ,non-assertive relationship		8				1					I would see them seperately, then together,to learn about the family of origin patterns of destructive behavior they are repeating ,ask , what would each like to be different so they could respond positively to one another.		8						5			
														Rules for safety would be established.				x							
44				2	8	2	0	0	1	0	2	2	0		2	8	2	1	2	0	0	5	0	2	2
ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G
45	2	1	First off, I am struck by the lack of clarity in regards to Carol's occupation					1						I would ask for seperate sessions at some point in the session to assess the risk, then I would ask them for their goals in regards towarding towards a solution -- what is it that you would like from me with reagards to help?								3			
			Why is James' occupation specified, and not Carol's?				1	1						But it may be true that Carol is on her way out, and if so, I want to know the risk of violence. I would also talk with them regarding the future of their relationship as co-parents and how they are going to work that out.	x					2	3			
			It would be important to first establish the balance of economic power that is being realized for future therapy session, and how it relates to their own cultural perspectives						1					If they choose to work it out, I want to assess the violence,	x						1			
			My first concern, however, would be to establish the violence probability in this family, and how Carol's safety is being taken care of.	x				1																	
45				1	1	2	0	1	0	0	2	2	0		1	1	2	2	2	0	2	7	0	2	2

ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
46	1	1	Since you sent this study to clinical supervisors, and I am a supervisor, I would have to ask the supervisee (therapist) before I would even touch this case: 1) Has child protective services been called?	1						1				If a supervisee who came to me with this story, I would see them as having not been clear about the mandatory reporting laws in our state, and I would have to make sure he/she followed through appropriately					x						
			What do you need to do for immediate protection of the children would be my ethical and legal first concern.	1						1																
			Why wasn't this handled when the therapist first talked to the wife?					1																		
			What reporting steps need to be followed now?	1																						
			Until the first issue was resolved to my satisfaction, I would not feel comfortable discussing any further issues with my supervisee.																							
			Other questions, such as: 2) Who is the client--the wife, the husband, the couple, the family?				1	1	1																	
			3) Under what conditions did this couple come to the therapist's office?						1																	
			4) what theoretical rationale did you use to determine to talk to each person "privately?"						1																	
			might be appropriate later to retrack the supervisee's steps and establish some different options for future couple's counseling						1																	
46				1	1	2	1	2	4	2	2	2	0		2	8	2	2	1	0	0	0	0	2	2	0
ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
47	1	1	Domestic violence is occuring, with Carol being afraid and unable to tell James what she wants or needs, and James feeling insecure and trying to control.	x			1	1						I would ask them jointly if they feel free to say what they are thinking and feeling								3					x
			Secrets and peer communication are present											If not (I suspect at least one of them would say no), I would work on safety issues								2					
														I would probably refer her to a domestic violence center as well.	x						1						
														I would try to let James know that I understand his fears but that his attempts to control are pushing her away.						3	1						
47				1	1	2	1	1	0	0	2	2	0		1	1	2	2	2	3	2	0	0	2	2	2
ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
48	2	1	Domestic violence	x										Depends on what the wife wishes to do.		8					1					
														She should be supported in her decision since she has to deal with the consequences of a decision to either remain or leave the relationship.		8					3					
														If she has sought a protection order, things will proceed as it is served		1					1					
														In the meantime, an appearance of normality (shopping, etc) is not a bad plan		8										
														She should not confront him in session or alone.		1				1	1					x
														I would not see her alone.							1					x
														The fact that the therapist has already seen him alone and her alone without a release already puts her in a legally vulnerable situation (see Margolin article).		7				1	1					x
48				1	1	2	0	0	0	0	2	2	0		2	8	2	2	2	2	8	0	0	2	2	2

ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	AI	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	AI	G	T
49			This couple has constructed a conflictual and violent system of relating	x					1					I would begin with these important issues: a. develop systematic family history inventory regarding intergenerational material and that of the clients												
														(It would be anticipated that using guided interview techniques the issues of violence and family conflict would become revealed.)	x											
														b. establish some contractual agreement that they commit to a non-violent context that is necessary for therapy to procede	x							1				
														c. discuss the legal and ethical issues when physical violence is present in a family	x											
														d. develop a framework in which the couple can assess the goals and objectives that they have for themselves as individuals, a couple and family.								3				
														e. based on this assessment develop a procedure to work toward these goals and objectives in a systematic manner.												
49				1	1	2	0	0	1	0	2	2	0		1	1	2	2	2	0	0	4	0	2	2	0
ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	AI	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	AI	G	T
410	2	1	Who knows?		9									Probably ask the wife what she is wanting from the therapy - does she give me permission to take her information into a joint session?		9					4					
			Could be someone is lying or hiding the truth		7				1					Is she interested in doing anything with the marriage, or simply trying to get out by some indirect ways.		9					1					
			At any rate there are major problems.		8									It appears that the husband is interested in keeping this marriage going - altho it may be by bullying her.		9				1	1					
														But, the wife seems to be giving messages that she wants out.		9					2					
														This must be resolved before continuing with couple work.												
410				2	8	2	0	0	1	0	2	2	0		2	8	2	2	2	1	8	0	0	2	2	0
ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	AI	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	AI	G	T
411	1	1	Possible domestic violence, possible extra marital relationship; certainly marital problems.	x										Are you asking this as a therapist or as a Supervisor?												
														I may recommend to therapist that safety issues be discussed and assessed and arranged first.				x								
														At least temporary separation be encouraged.												
														Assess couple together and separately.						1	1	1				x
														Don't place therapist in middle of triangle with secrets...so share what has been said (with releases as needed).												
														Gather goals at each and together...and proceed.						1	1	1				x
411				1	1	2	0	0	0	0	2	2	0		2		2	1	2	2	2	2	0	2	2	3

ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	AI	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	AI	G	T
412	2	1	This is a case involving alleged domestic violence.	x										The case formulation itself is unclear.													
			It is not clear that there has been a mandate report of child abuse, which depending on the state requirements, is likely required							1				The last sentence suggests that the whole family is present					x			1					
			If this report has been made then issues of domestic violence would be overt in parental and marital process						2					What the therapist's contract is with the client(s). Is this family work, couple work?								1					
			It is also likely that if the kids were in danger that the social services agency would intervene to provide protection from further abuse by the father.							1				If it is couple work then why are the kids present at the session?								1	1				
			This would significantly effect how the therapist would intervene regarding the family situation.											If there is reasonably suspected child abuse, wouldn't the kids be in their own therapy process?									2				
			It is not clear how the therapy has developed.											These issues are not clear.													
														Without a context for the treatment it is difficult to reason what an appropriate intervention would be?													
														I take it from the last line of the scenario that this researcher is concerned with what a therapist will do in light of the possibility that the session could escalate the likelihood of violence following the session.	x													
														The therapist actions in this case would be informed based upon how they had structured the therapeutic contract with the clients.								1					
														Had the therapist made clear how they would handle secrets between couple members, the issue of the wife's disclosure would have been anticipated.							1	2				
														If anticipated the course of treating this couple conjointly at this point would have been avoided								1				1
														The therapist could have worked separately with each partner to clarify the degree of conflict escalation and work with each partner individually to clarify what options they had.								3				
														The therapist could then make clear to both parties independently what the limitations of conjoint treatment are with domestic violence	x							1				1
														The case scenario lack verisimilitude.													
														The organization of the case lacks structure and this makes it difficult to anticipate a response / intervention.													
														Relevant details are missing from the scenario, so anyspeculation about intervention is premised upon a number of different conditions and without their identification the answers to the question lack necessary context.													
412				1	1	1	0	0	2	2	2	2	0		1	1	2	2	1	0	1	11	3	2	2	1

ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
413	2	1	Probably "battered wife" syndrome.	x										Get a contract of temporary separation to get him out of the house immediately.						1						
			She says she has "made efforts," but she is still with him				1	2						Then, working with them seperately, find out where the anger and violence come from, and define changes he wants to make in his life so he no longer feels the need to have power and control over his family.	x					4		1				1
			As for him, I would look at issues of power and control, cycle of violence, self-esteem, parenting skills, communication skills.				1							With her, we would work on self esteem, understanding the cycle of violence and safety issesues.				x			1					
														In a situation involving violence, the first issue must always be safety.	x			x								
413				1	1	2	2	2	0	0	2	2	0		1	1	2	1	2	5	1	1	0	2	2	1

ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
414	2	1	There could be a few different things going on in this family, depending on how reliable and honest each person is being						1					Since each of the disclosures were made to the therapist in private, I think I would attempt to get each one's permission to discuss their private disclosures in a conjoint session								2					x
			If we accept what Carol reports, then this sounds like extreme marital conflict resulting in physical violence and spousal abuse	x				1						I would do this individually, and during this time make an assessment regarding the immediate safety of Carol and the children as well as the potential danger that might arise after a conjoint session to address the physical violence.	x						1		1			x
			I sound like there could also be child abuse and the need to involve protective services							1				If permission was granted to discuss this issue in a conjoint session and there was not an imminent safety risk, I would meet with the couple and discuss a no- violence agreement	x				x		1	1				
														I would say to the couple that I would not do conjoint therapy if violence were to continue.	x							1				
														I would refer James to an anger-management group.						1						
														I would also ask to speak with the children individually and ask them about their safety in the home.									3			
														If there is the slightest concern, I would notify child protective services immediately.					x							
														If I felt Carol and the children were in serious imminent danger, I would recommend that Carol call from my office a domestic violence shelter if one were available, or to phone the police prior to leaving my office.							2		1		1	
414				1	1	2	0	1	1	1	2	2	0		1	1	2	2	1	1	4	4	5	2	1	4

11				0	12	2	11	6	1	0	2	2	2		1		2	2	2	2	2	1	3	2	2	1

ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	AI	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	AI	G	T
415	2	1	Interpersonal trust is in question											Determine if Marital Therapy is feasible for the partners								1				
			Communication skills are lacking, and acting out is occurring											If Marital Therapy is not feasible, serve as consultant to the partners regarding their destructive behaviors								2				
			Violence is a a strong possibility	x										Determine method for intervening with possible violence--i.e,. husbands's ego strength, need for referral program, wife and children's safety	x					1	1		1			
														Review implications for wife and childen and their need for attention--ask wife regarding need for legal intervention, safe house, and other safety plans				1			3		2			
														Intevention: marital therapy?, pre-marital therapy relative to trust and and communication breakdown and grief?												X
														assess role of violent interactions and determine recommendations for the partners	x											X
														When marital therapy is feasible, contract for review of breakdown of trust and observe partners motivation for facing grief, work with couple on communication in therapy												X
415				1	1	2	0	0	0	0	2	2	2		1	1	2	1	2	1	4	3	3	2	2	4

			If so, was it in a place where he could reasonably expect to be seen?		1

Male Perpetrator Vignette

Iowa Supervisors

ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	AI	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	AI	G	T
51	1	3	stated domestic violence & attempts for protection order	x	1									Information about domestic violence + safe house explore immediate safety and discussion for family outing if necessary.	x			x								
			possible chid abuse		2					1				BDI (Brief Drinking Inventory), substance abuse assessment if history supports this intervention										x		
			possible substance abuse & marital infidelity		8						x			Report child abuse (inform parents first)					x							
			marital dissent + stated attempts at seperation		8									Discussion with husband regarding stated abuse						1						
			denial of toxic issues in family		8									If wife agrees to go to safe place, talk with couple together about future sessions + individual work - wife comes first							1					3
			rigid communication bounderies + secrets affecting therapist		8									Assess for bruises, medical attention necessary, determine authenticity of abuse												
			wife fear of husband future violence towards herself and the children		1		1	2		1																
			husband fear of loosing his wife to another man + substance abuse		8		2	1																		
			probable emotional traumatization for children		8																					
51				1	1	2	3	3	0	2	1	2	0		1	1	2	1	1	1	1	0	0	1	2	3
ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	AI	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	AI	G	T
52	2	1	A lot of disorganization and malfunctioning											If physical violence is confirmed, I'd want to negotiate immediate stoppage of that.	x											
			Trust has been / is being damaged, perhaps beyond repair.											Initially, I'd see the entire family together and develop a more complete, yet brief (for now) family history. I'd want to know each person's perceptions of their family, one another & selves as individuals.								3				2
			Secrets and outright deceptions are evident.											As their perceptions are explored, I'd want to know what each member would like to see change, as well as to remain the same, i.e. likes/dislikes. Then I'd want them to select one thing that they could work on before the next session								4				
			Conflicts are mismanaged and abuse is reported (as well as physical violence)	x										Then I'd explore their success and failure & ascertain what, if anything, they were willing to do in the immediate and long range future.												
			The last line suggests they <u>may</u> (but also may not) do things together that are enjoyable (and I'd be surprised if they are not deeply in debt, if their planned outing is typical and frequent).																							
52				1	1	2	0	0	0	0	2	2	0		1	1	2	2	2	0	0	7	0	2	2	2

ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
53	1	1	I don't know who is present at this session - what has already transpired in therapy. Is this individual, couple or family therapy?											I would be very uncomfortable intervening at all with this limited info													
			Domestic violence, child abuse, marital conflict, fear-anger?	x										Would want to do further assessment / gathering of info.													
			Numerous other possibilities											Report child abuse to DHS.					x				1				
														Provide for safety of women/children - best safety plan available.				x			1		1				
														I would not be seeing couple/family together had Carol told me there was physical abuse of her and children and it occured as recently as yesterday.							2		1				x
														Possibility of increased violence if not handled very judiciously - even with careful intervention, possibility of increased violence.	x										x	
														Assess individuals, couple, family re: changes / losses/ stressors.								1				
														Assess each partner in marriage for depression/anxiety/ other psychological disturbances/disorders.								1				
														Possible referral for individual counseling for both adults.								1				
														Possible referral for therapy for children.									1			
														Referral to Domestic Violence intervention project for women.	x						1					
														Safety would be my paramount concern for this family.				x								
														So, need means to protect family members from escalation of violence should it occur.	x			x								
														This is a complex case with high risk factors.											x	
53				1	1	2	0	0	0	0	2	2	0		1	1	2	1	1	0	4	3	4	2	1	1
ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
54	1	1	Family violence	x										Make the violence the issue	x											
														1st say nothing else can proceed until a safety plan is established and no violence contract made.	x			x								
														Depending on degree I might push for a restraining order for him not to see family for now and until he is in treatment.						2						
														Legal issues before any family therapy.												
54				1	1	2	0	0	0	0	2	2	0		1	1	2	1	2	2	0	0	0	2	2	0

ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	AI	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	AI	G	T
55	1	1	The cycle is wife puts away (i.e. stays out late has other relationships), husband trys to control		8		1	1	1	0				#1. Show the cycle												
														#2 No more violence, husband to attend domestic battery classes	x					1						
														#3 If any more violence, I will refuse to stay on as therapist + will insist wife press charges.	x						1					
														#4 Give assignments to stop the process												
														i.e. A. Wife to demonstrate respectful behavior - call when going to be late, be honest of who she is with.							2					
														B. Wife list out what behaviors she wants different in the marriage							2					
														C. Husband to be more respectful, no more violence	x					1						
														D. Husband to list out what changes he wants different in marriage												
														E. Couple to negotiate on making the differences in the marriage												
55				2	8	2	1	1	1	0	2	2	0		1	1	2	2	0	2	5	0	0	2	2	0

ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	AI	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	AI	G	T
56	1	1	I would not assess anything with this little information											Ask questions, questions, questions.		8										
														Listen, listen, listen.		8										
														See them together at least for the assessment if she is safe.		8										
56				2	8	2	0	0	0	0	2	2	0		2	8	2	2	2	0	0	0	0	2	2	0

ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	AI	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	AI	G	T
57	2	1	Possible domestic violence, possible marital infidelity, possible marital difficulties; possible neglect by the mother	x				1						The law dictates 1st interventions if children are being physically abused - talk to children - determine whether there is a need to report to DHS.	x				1				1			
			Impossible to know for me - not enough information											If reportable, report - encourage mother and children to go to shelter for safety.					1		1		1			
			Who is presenting for therapy? Unclear? Definitely give more information that what is provided																								
57				1	1	2	0	1	0	0	2	2	0		1	1	2	2	2	0	1	0	2	2	2	0

ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
58	1	1	Physical abuse by James, conflict abolidence by Carol	x		x	1	1						Set up safety plan with Carol about what to do in immediate future				x			1				1	
														It would include the # of the local shelter and instructions for the kids of action to take if violence occure.	x											
														I would discuss a longer term plan with Carol regarding divorce timing and custody issues.							1					
														With James, I would discuss his anxiety and how it puts him in the position of pursuer.						1						
														I would suggest strategies for managing anxiety + expressing frustration and anger appropriately.												
														In this situation I would proceed with individual counseling not marital.												x
58				1	1	1	1	1	0	0	2	2	0		1	1	2	1	2	1	2	0	0	2	1	1
ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
59	2	1	Both parties in marriage are bending the ear and triangling the therapistr to paint the other partner to loook bad (mutual blaming)		7				1					Coach woman to have protection order, not simply to "seek" and to insure safety with seperation for her and her children if in fact there is repeated physicall violence.				x			3					
			James is attempting to control Tracy into relationship through physical means.		6		1	1						Coach James into violence based group.	x					1						
			Tracy seems to be out of it already but hasn't let James know yet		6		1	1						Ask each person (after safety is insured) what the marital goal is. (i.e. to build marriage, or to divorce)				x				1				
					7									If it is to build, contract for specific plan, if it is to divorce assist communication clarity for the sake of the children.									1			
59				2	7	2	2	2	0	0	2	2	0		1	1	2	1	2	1	3	1	1	2	2	0
ID #	Gn	R	What's happening in this family?	VA	Th	AA	J	C	B	Ch	Al	G	T	How would you intervene?	VA	Th	AA	S	RCA	J	C	B	Ch	Al	G	T
510	3	3	Domestic violence, effecting all family members	x										Arrange with Carol immediately for safe shelter for her and the children				x			1		1		x	
			Unresolved childhood abuse for both Carol and James				1	1	1					I'd see them seperately - James, to work on anger management and dealing with possible/likely unfinished childhood trauma, making ammends, future relations with kids.						1		1				x
														Work with Carol and kids on trauma recovery and other issues.							1					
														After these goals have been met, do family therapy sessions for future relationships - divorce & major family events; e g helping family set plans for next 2 years - whether divorced or reconciled.												x
510				1	1	2	1	1	1	0	2	2	8		2	1	2	0	2	1	2	1	1	2	2	4

Violence as secondary theme

Female Perp Vignette			
ID	Theme	Response Q1	Response Q2
11	questioning veracity	Wife in her unfortunate way seems desperate to hold onto him. Why?	Separate interviews (a) to minimize provocations of further violence, but mostly (b) to try for private and genuine statements of what these people really want.
		I hear nothing here of the pitiful guilt that often seems to follow violent outbursts of husbands (for a time), and wonder why he failed in getting a restraining order	If we get that, we are halfway home to a resolution
		Where are the forces of law and order (at least for the kids)?	Someone needs to see the kids, who may or may not add reality to the picture (since they are as likely to be biased as anyone), but they are surely at risk.
		The husband claims to want out, but sails along on business as usual.	
		Perhaps he too has wants that are not quite what he tells us, her, or himself (as in staying married with a little wandering now and then).	
		Then of course there is the possibility that some of the private talk was private because it would be denied by the other spouse, and might actually be false.	
		Of course, we can count on the wife claiming that she gently pushed husband out of her face, wherein he tripped on something and fell dramatically, but this adds nothing to real information about the truth.	
		Was husband really with other woman?	
		If so, was it in a place where he could reasonably expect to be seen?	
32	don't know, need more info	Can't say for sure unless you really get to hear from both with a lot of listening.	Meet with both for one or two weeks, and then see each spouse individually .....
		Need to place all behaviors into a context with a history, even three generational issues, understanding of losses, and past painful experiences.	they both need to be willing to work on the issues in the marriage in order to make progress in that area.....
		Would help to view their relationship strengths and how it has evolved with some time spent understanding disappointments and positive times.	..work individually until you can have both ready to work..
		There is some chance the husband is having an affair and that this has provoked the wife into her losing control.	.If the husband is involved with another woman,I would ask that he stop seeing her in order to give his marriage his best effort.
		However, her violence may be pushing her husband away and making it hard for him to find solutions to their problems.	after all he came into therapy with the idea that something could happen, and he will feel best if he gives the marriage his best shot..
			if it can't work after a sustained great effort, then so be it, he may have a situation that is very tough.....even then miracles can happen.
			I'd become solution focused at some point during therapy...

	Reasons for Non-Participation	13 Time	5 Info lacking	3 Get too many	1 Misplaced	2 not re suprv.	4 not sound rsrch	1 fear of judgmnt	< Totals
1	I can't tell you how many requests I get and how busy I am. I do my best	1							
	to respond to what I can. I do my utmost to complete surveys I see as								
	quick and demand little of my time.								
	I'm assuming my colleagues are in a similar boat. I'm sorry and hope this								
	helps.								
2	I have misplaced your material - sorry to say. I had an office move.				1				
	Also, I have received so many of these requests. Sometimes, people need			1					
	to wait for a reply. If you want, send me another.								
3	Thanks for your persistence in obtaining responses to your survey. The survey								
	itself seems to be quite vague in content and questions. There is not enough		1						
	information provided to answers the questions -- more clinical data is needed.								
	Perhaps that is the answer you are looking for. Hence, the slow and								
	incomplete response. Please let me know if I can be helpful in your research								
	efforts in other ways.								
4	It's not that I don't have the intention of helping you, it's just that I have an extremely busy and tight schedule, and things like these tend to fall to the bottom of my priority list. I tend to not believe people when they say, "It will only	1							
	take X minutes" - in my experience, something worth doing is worth investing time in. Also, since this is labeled as a "clinical supervisor survey", I don't see it as a survey, and I don't see the connection to supervision. It seems more like an exam ques					1			
	I hope that these comments are helpful.								
5	I did not respond to your survey because I saw absolutely no relevance					1			
	to supervision. How I conceptualize cases myself has very little to do								
	with how I help others conceptualize them.								
	You asked: >								
	> 1. What is going on in this family?								
	I have absolutely no idea. I would need a lot more data, especially from		1						
	my own clinical interview, to even begin a conceptualization.								
	> 2. How would you intervene?								
	Ditto								
	> 3. Anything else that might be helpful for this research?								

5	I don't know what you are asking? How can I be helpful if I don't know what the research is?								
	I hate to even respond to this message because I fear that you will include it in your response rate, which might lend weight to conclusions you draw from the data. I am responding only because you wanted to know why people were not responding. We get a lot of requests for participation in research over email. Typically, I weigh the apparent soundness of the research before I spend time responding. This project did not merit such time.						1		
6	Too many surveys come my way for me to respond to. As a program director, I feel deluged with graduate student and faculty research invitations through the internet. The easiest ones to fill out are those that just ask me to check boxes. Yours is more interesting but requires me to think, time for which is in short supply. Sorry to not be more helpful to you.	1		1					
7	to answer the questions about a description for me is so incomplete as there are so many "it depends" that cannot be obtained - even if this were the therapist's description to the supervisor, I would still be able to obtain information about what the interactions were before the clients were seen privately...and the therapists perceptions about the couple and the children.		1						
8	The answer to your question, why I didn't respond, can be found in your statement. Please keep your responses to questions 1 and 2 brief. How??						1		
9	I am sorry I have not responded to your survey. Two things are at issue: I get inundated with e-mail research surveys and it is just not possible to respond to each one. The second is that I had a death in the family, which took me away from my office			1					
10	I usually like to support this type of research - I am into supervision and case conceptualization and I like to support COAMFTE doctoral student research. However, I am concerned that you have not spelled out how confidentiality will be kept (e-mail is not very confidential) and I am also concerned that you indicate it will only take 5 minutes. It is hard to think about, let alone write out how to conceptualize a complex case such as the one you present in 5 minutes -						1		
	seems more like a 10 to 20 minute venture.With that said, I am still willing to fill it out if you are willing to provide more information on how my answer will be confidential. I would also like to understand where you are coming from on the time issue.	1							

		Time	Info lacking	Get too many	Misplaced	not re suprv.	not sound rsrc	fear of judgmnt	
1	Regrets. Do not wish to participate in this type of research.								
2	I wish I could participate in your survey but I cannot. There are so many gaps in information - so many questions I would ask - before I could begin to respond to such survey questions as "What is going on in this family?" Sorry		1						
3	Kathleen, I did respond to the survey, but I htink it was hard to answer the questions based on so little information...What's going on in this family can't be determined by such little information, and in a real interview you get so much information		1						
	that you have to decide what's not important more than what is important. Also, there is a fear of being judged based on the factors of gender and race and the concern that the data won't be accurate or that whatever conclusions you reach won't be valid							1	
	or true based on this scenario that has been presented....if we saw a video tape of them in a family therapy session and were then asked the questions, it would be different...Best wishes to you in your career						1		
4	I am overwhelmed with work, family, taxes, annual review, etc., and this seems urgent, have no time especially in March, middle of the semester.	1							
5	Sometimes it just takes more time than you alot. I was once told: plan the amount of time you need....then multiple it by 3. I'd like to help, just need a little longer to reply. Good luck.	1							
6	I know that you worked very hard to get your survey to be as simple as possible, unfortunately, your request arrived during that period in my life when one more thing would be impossible.	1							
	I really feel badly that I can't help you right now. I supervise at an agency and teach at San Diego State University and student interns are among my favorite people.								
	Best of luck on your project.								
7	Ordinarily I would have replied. I looked at it and realized I would have to think it out and create a real treatment plan (for me, a real one, not a phoney for an HMO) because there are several different responses that I would make for every trial								
	balloon I tested. I know this complicated it needlessly, but why bother if it's just garbage, and I herniated a disc in my back two weeks ago, and decided doing the survey was not where I would best put my present energy. Sorry. I know you need them	1							
8	Kathleen - I did respond - these research questions are really time consuming (more than what is ever suggested) and everyone is always really busy - I suspect that is why you haven't had a better response. If there was only one question instead of a	1							
	whole series you might have better luck. Good luck.								

		Time	Info lacking	Get too many	Misplaced	not re suprv.	not sound rsrc	fear of judgmnt	
9	I'm sorry to have not been able to help with your research project. Our division has been very busy in the last few weeks with legislative efforts and our annual conference. We have more legislative meetings this week, so I am not sure when I will be a	1							
	to respond to your questions. I would like to do so when I have time to give it the thought it deserves. When I am doing supervision, I work with the therapist about how she/he is using themselves with the client family vs how I would intervene								
	That makes it a little difficult to formulate my response to you.								
	Good luck with this project.								
10	Haven't responded because it would take far too long to appropriately respond to the vignette questions & I just don't have the time to write what would be, in effect, two major essays. Best of luck.	1							
11	Busy	1							
12	I am swamped - 10+ therapy sessions a day and then administration	1							
	responsiblities and them managed care. I hope to get to your survey								
	soon.								

APPENDIX E

WEB SITE

CLINICAL SUPERVISOR SURVEY STUDY RESULTS

March 30, 2001

Welcome,

I would like to extend a particular thank you to all who completed surveys for this study, or who were kind enough to let me know their reasons for non-participation.

I have created this site both to provide information about the research, and to provide for discussion. Too often researchers and clinicians live and work in separate spheres. I will be relying strongly on your comments as I discuss the results of this study in the final chapter of my dissertation.

You may rest assured, however, that while quotes may be used, I will not identify you by name even if you have chosen to identify yourself on this discussion board. Comments are invited from all visitors, both about the study and the preliminary study results.

With my appreciation for your time and consideration,

Kathleen M. Adams
Ph.D. Candidate
Human Development and Family Studies
Iowa State University
adamskath@aol.com

CLINICAL SUPERVISOR SURVEY RESULTS

STUDY HISTORY AND GOALS

As you may have imagined, this study is part of my dissertation. Clinically, one of my areas of interest and expertise is in violence and trauma in families. I have discovered that our professional literature is rife with criticism of how we (MFT's) respond to cases involving acts of violence (e.g., Crnkovic, Del Campo, & Steiner, 2000; Harway, Hansen, & Cervantes, 1997; Shamai, 1996; Hansen, 1993; Harway, Hansen, & Cervantes, 1991; Pressman, 1989; Goldner, 1985; Bograd, 1984; Cook & Franz-Cook, 1984, James & McIntyre, 1983).

This criticism in the literature seems to take two forms. Some state that a significant number of us (MFT's) don't recognize violence in families when presented with it (e.g. Aldarondo & Strauss 1994; Holtzworth, Munroe et al ,1992), and others state that when violence is recognized, a significant number of us intervene without understanding the kind of power that the perpetrator of the violence (usually male) has in controlling the family (e.g. Shamai, 1996).

This left me wondering about how AAMFT Approved Supervisors respond. I discovered there is virtually no research at all on the clinical competencies of supervisors, that the research on supervision overall is minimal, and that what there is focuses primarily on the dynamics of the supervisory relationship.

I then developed this study, in part, to satisfy my own curiosity about how supervisors conceptualize and respond to cases where violence is being perpetrated. It has three goals:

- The first goal is to determine to what extent the awareness of the Approved Supervisors in this study reflects or contradicts the reports in the literature about the poor awareness that we (MFT's) have regarding violence in families.

- The second goal is to explore how the language that the Approved Supervisors in this study use addresses the issues of agency (responsibility) for the violence. For example, "She is being violent toward him and the children," directly names her as the agent of the violence. "Domestic violence," or "family violence" effectively obscures that agency.

- The third goal is to generate discussion, and increase awareness among approved supervisors, about the issue of MFT response to violence in families.

GO TO DISSERTATION ABSTRACT

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CLINICAL SUPERVISOR SURVEY RESULTS

STUDY DESIGN

I sought a study design that would provide ease for participants while still garnering substantive information. I wanted also to be able to compare and contrast the results of my study with information in the literature. Additionally, it was important to me to be able to involve study participants, and interested others, in review and discussion of the preliminary study results, and to include that feedback in my own documentation of the research.

To these ends I structured a very simple, two question, survey using a case vignette used by Harway, Hansen & Cervantes (1991, 1997) in their studies of MFT response to violence in families. In those studies, 40% of those participating did not address the violence in responding to the case vignette. Of the 60% who did address the violence, very few addressed the crisis nature of the situation.

Because of my curiosity about how gender of the perpetrator might effect how we view these cases, I changed the agent of perpetration from the male to the female in the survey sent to half of those invited to participate. Everything else in the vignette remained the same. (See, study limitations.)

Many of you had questions and concerns about my use of this vignette, particularly regarding the clinical complications presented by the reported fact that each partner had revealed critical information to the therapist privately. (See, surveys.)

In e-mail conversation with Michele Harway, I asked about the vignette's creation. I learned that she and her co-author Marsali Hansen, created this case vignette from public information about an actual Pennsylvania court case. The husband was convicted of murdering his wife after using what was reported as the *"bitch deserved it"* defense. The researchers included all the descriptive information available to them in creating the vignette. To their knowledge, the couple did not actually seek therapy. Information about therapy was the only information they inserted into the vignette that was not in the original case information.

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CLINICAL SUPERVISOR SURVEY RESULTS

DATA ANALYSIS

Critical discourse analysis was used in the preliminary analysis of participant responses. Responses were read as a whole, then reviewed on a sentence by sentence basis, and then again reviewed in paragraphs. (Ongoing analysis is focusing on categories of response within themes, and emergent themes.)

For more detailed information about each of the categories below, see qualitative analysis.

Each sentence was coded either "yes" or "no" for the following:

Was the violence addressed?
Was agency for the violence addressed?
Was safety addressed?
Was reporting child abuse addressed?
Was the gravity of the violence addressed?

Each sentence was further coded quantitatively for the following:

How many reference to James are made?
How many references to Carol are made?
How many references to both are made?
How many references to the children are made?

Additionally, each sentence was coded for reference to therapeutic modality:

No particular modality mentioned
Individual therapy recommended
Couples and family therapy recommended with no reference to safety
Safety first, then couples or family therapy

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CLINICAL SUPERVISOR SURVEY RESULTS

QUALITATIVE ANALYSIS

Examples:

Was the violence addressed?

Yes: "violent outbursts"
"physically abusive"
"domestic violence"
"physical violence"

No: "abuse accusations"
"conflict"
"abusive situation"
"using physical means to control"

Was agency for the violence addressed?

Yes: "husband's violence"
"Carol has been physically abusive with James"
"violent husband"
"she is violent"

No: "domestic violence"
"the violence"
"violence of children"
"physical violence"

Was safety addressed?

Yes: "augment safety"
"safety planning"
"safety comes first"
"intervene for immediate protection of children"

No: not addressed

Was reporting child abuse addressed?

Yes: "report child abuse"
"report to social services for abuse of child"
"... mandates a report in this state"
"if reportable, report"

No: not addressed

Was the gravity of the violence addressed?

Yes: "very concerned about ... escalating ... violence"
"safety issues imminent"
"plans for after the session would have to be cancelled"
"need for immediate intervention / protection"

No: immediacy, crisis nature of case, or severity of violence not noted

Each sentence was further coded quantitatively for the following:

How many reference to James are made?
James, him, his, himself, husband, father

How many references to Carol are made?
Carol, her, hers, herself, wife, mother

How many references to both are made?
Couple, both, them, their, theirs, parents, partners, they

How many references to the children are made?
Children, kids, they, their, them, theirs

Additionally, each sentence was coded for reference to therapeutic modality:

No particular modality mentioned
Individual therapy recommended
Couples and family therapy recommended with no reference to safety
Safety first, then couples or family therapy

RETURN TO ANALYSIS

RETURN TO PRELIMINARY STUDY RESULTS

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CLINICAL SUPERVISOR SURVEY RESULTS

PRELIMINARY STUDY RESULTS

195 approved supervisors were invited to participate. 172 of those were invited by e-mail with two 2 e-mail follow ups. 86 were sent the vignette presenting the male as the perpetrator. 35 of them returned a completed survey, for a return rate of 41% Of the 86 who were sent the vignette presenting the female as the perpetrator, 19 returned completed surveys, for a return rate of 22%. An additional 21 supervisors responded by providing reasons for their non participation.

Additionally, 22 of the 25 approved supervisors in Iowa were invited by regular mail, (with 2 mailed follow ups and one phone call follow up) to complete the male perpetrator version of the survey as part of a pilot study for this research. 10 completed surveys, for a return rate of 46%.

Overall the study reviewed completed surveys from 54 participants, for a 28% participation rate. This is low for a survey with two follow ups (Dillman, 2000).

25 participates identified as male, 24 identified as female, and 5 did not provide information about gender. 45 participants identified as white or Caucasian, 3 identified either as African American, Latina or Creole, and 6 did not provide information about race.

Female Perpetrator Vignette

Of the 19 participants responding to the female perpetrator vignette, 12 (63%) noted the violence, 7 (37%) did not note the violence. 4 (21%) noted agency for the violence, 15 (79%) did not note the agency. 6 (32%) addressed safety concerns, and 13 (68%) did not address the need to establish a safety plan. 6 (32%) stated they would report the child abuse, while 13 (68%) made no mention of reporting the child abuse. 3 participants (16%) made note of the severity of the violence or resonded with immediacy, while 16 (84%) did not address the severity, immediacy of the need for safety, or the crisis nature of the case.

Of the 12 participants who did note the violence, 2 did so secondarily. The theme of one of those responses regarded doubt about the veracity of the information provided by the partners, while the other response focused on the need for additional history gathering by meeting with the couple for two weeks before making

any determinations.

The themes in the responses of 3 of the participants who did not note the violence shared an emphasis on conflict, anger, therapist triangulation and secrecy. One stated that "physical methods" were being used to address the conflict. These three participants recommended joint sessions in which the conflicts would be addressed openly. The themes in the responses of the other 4 participants who did not address the violence were:

- family chaos
- conflict, abuse, establish safety
- don't know, communication problems, power
- don't know, aggression, intimacy problems

16 (84%) discussed the type of therapeutic modality they would employ. 3 (16%) made no mention of therapeutic modality. Of those who did mention modality, 14 (or 40% of the 35 participants) noted they would work individually, or establish safety first and then decide on the therapy mode. 7 (20%) of the participants stated they would utilize individual and couples therapy without mentioning regard for safety issues

Male Perpetrator Vignette

Of the 35 participants responding to the male perpetrator vignette, 32 (91%) noted the violence, 3 (9%) did not note the violence. 5 (14%) noted agency for the violence, 30 (86%) did not note agency. 19 (54%) addressed safety, 16 (46%) did not address the need to establish a safety plan. 10 (29%) stated they would report the child abuse, 25 (71%) made no mention of reporting the child abuse. 7 participants (20%) made note of the severity and immediacy of the situation, while 32 (91%) did not address the severity, immediacy of the need for safety, or the crisis nature of the case.

Of the 3 participants who did not note the violence were, 2 participants stated that more information was needed than what was provided in the case vignette in order for them to respond. The third participant who did not note the violence stated the vignette described "destructive behavior" and emphasized assessing same and establishing safety.

21 (60%) mentioned the kind of therapeutic modality they would employ. 14 (40%) made no mention of therapeutic modality. Of did mention modality, 14 (or 40% of the 35 participants) noted they would work individually, or establish safety first and then decide on the therapy mode. 7 (20%) of the participants stated they would utilize individual and couples therapy and did not make mention of the

safety issues.

PRELIMINARY STUDY RESULTS

Concern	Female Perp	Male Perp
noted violence	12 (63%)	32 (91%)
violence not noted	7 (37%)	3 (9%)
addressed agency	4 (21%)	5 (14%)
agency not addressed	15 (79%)	30 (86%)
addressed safety	6 (32%)	19 (54%)
safety not addressed	13 (68%)	16 (46%)
addressed reporting child abuse	6 (32%)	10 (29%)
reporting child abuse not addressed	13 (68%)	25 (71%)

Concern	Female Perp	Male Perp
noted gravity of violence	3 (16%)	7 (20%)
gravity of the violence not noted	16 (84%)	32 (91%)
addressed mode of therapy	16 (84%)	21 (60%)
mode of therapy not addressed	3 (16%)	14 (40%)
individual therapy, or safety first	5 (26%)	14 (40%)
individual and couples, safety not addressed	11 (58%)	7 (40%)

For examples of phrases, categories, and coding, see qualitative analysis.

REASONS FOR NON-RESPONSE

19 of the 172 participants who were invited to participate by e-mail were kind enough to let me know their reasons for not participating in this research. Additionally, 2 individuals who did complete surveys shared their ideas about possible reasons for non-response. 6 primary themes emerged in review.

Misplaced survey 1 individual reported that "the survey had been misplaced"

Get too many research requests to respond to all 5 individuals reported something like this quote, "I can't tell you how many requests I get and how busy I am. I do my best to respond to what I can."

The survey demands too much time 12 individuals reported something similar to this quote, "Your (survey is) ... interesting but requires me to think, time for which is in short supply," or "Answering these questions will take much more time than stated."

Case vignette does not provide enough information 5 individuals. For example "There is not enough information provided to answers

the questions -- more clinical data is needed."

Research project is not sound 5 individuals. For example, "I did not respond to your survey because I saw absolutely no relevance to supervision. How I conceptualize cases myself has very little to do with how I help others conceptualize them." Or, "The answer to your question, why I didn't respond, can be found in your statement.' Please keep your responses to questions 1 and 2 brief.' How??" Another expressed concerns about the confidentiality of e-mail, and trust regarding how I would maintain confidentiality and manage returned e-mails.

Participant anxiety, trust concerns 1 individual, who did participate, suggested, "there is a fear of being judged based on the factors of gender and race and the concern that the data won't be accurate or that whatever conclusions you reach won't be valid or true based on this scenario that has been presented...."

RETURN TO ABSTRACT

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CLINICAL SUPERVISOR SURVEY RESULTS

STUDY LIMITATIONS

- This is, by design, a small modified qualitative study. The results are not generalizeable. Great care should be taken in discussing these study results so that generalizability is not inferred.

- The characteristics of violence perpetrated by males are very different from the characteristics of violence perpetrated by females. The violence of women is not as severe or lethal, and is often in response to violence perpetrated by the male. The vignette described a not atypical case of severe violence perpetrated by a male, not by a female. In changing the gender identification of the perpetrator, I succeeded in creating a vignette severely lacking in verisimilitude. Consequently, any comparisons between responses to male and female perpetrator vignettes is cautioned, and if done at all should be weighed very, very carefully with differences in gendered patterns of violence in mind.

RETURN TO STUDY DESIGN

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CLINICAL SUPERVISOR SURVEY RESULTS

RECOMMENDED LINKS

Domestic Violence Education (http://www.dvcme.org): On line course designed for physicians, residents in all specialties, medical students, and other health care professionals. Excellent site developed by the American Medical Women's Association.

Domestic Violence: What to Ask, What to Do : (http://jama.ama-assn.org/issues/v284n5/ffull/jmn0802-4.html) Lamberg, L., (2000) Journal of the American Medical Association

Domestic Violence Treatment: Legal and Ethical Issues (http://www.daniel-sonkin.com/dvethics): Daniel Jay Sonkin, Mindy S. Rosenberg, and Douglas S. Liebert To be published in *Sonkin, DJ and Dutton, D (in preparation) Treatment of Intimate Violence: Multidimensional Psychotherapeutic Perspectives* by Haworth Press.

Domestic Violence: The Case for Social Advocacy (http://www.counseling.org/conference/advocacy10) Mary Smith Arnold and Karen Sobieraj American Counseling Association Advocacy Paper #10

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CLINICAL SUPERVISOR SURVEY RESULTS

ABOUT THE RESEARCHER

I am an MFT, ICSW, CAC III, and a Clinical Member of AAMFT. I have 20 years of clinical and administrative experience in pastoral counseling and community mental health, including 7 years in a large family service agency as the clinical supervisor of outpatient psychotherapy services. Because I am interested in teaching and training at the graduate level, I am currently completing my Ph.D. in Human Development and Family Studies, with a focus in Marriage and Family Therapy, at Iowa State University. My major advisor is Professor Harv Joanning, joanning@iastate.edu.

Kathleen M. Adams
Ph.D. Candidate (VITA)
Human Development and Family Studies
Iowa State University
adamskath@aol.com

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CLINICAL SUPERVISOR SURVEY RESULTS

DISSERTATION ABSTRACT

AAMFT Approved Supervisors response to a case vignette describing the perpetration of violence in a family: A modified qualitative study using e-mail surveys.

Dissertation Abstract

Kathleen M. Adams

Past surgeon generals of the United States have identified violence in families as an epidemic, and have called for an organized approach to screening, treatment, and prevention (Poirier, 1997).

Given that the family is the locus of this epidemic, sound reasoning suggests that family therapists would be leading the response. Research strongly counters that assumption. The literature spanning the last two decades has consistently documented that family therapists respond poorly to violence in families (e.g., Crnkovic, Del Campo, & Steiner, 2000; Harway, Hansen, & Cervantes, 1997; Shamai, 1996; Hansen, 1993; Harway, Hansen, & Cervantes, 1991; Pressman, 1989; Goldner, 1985; Bograd, 1984; Cook & Franz-Cook, 1984, James & McIntyre, 1983).

Poor therapist response appears to take two forms. A significant number of therapists do not recognize violence in families when presented with it (Aldarondo & Strauss 1994; Holtzworth, Munroe et al ,1992), and when violence is recognized, a significant number of therapists intervene without respect for power differentials (Shamai, 1996).

In the training of MFT's, the role of Approved Supervisor is key. The supervisor is responsible for determining the skill level and training needs of the MFT . There has, however, been no research examining the basic competencies of Approved Supervisors.

The current study has three goals. One is to determine to what extent Approved Supervisors' awareness of violence in families reflects or contradicts the poor awareness of MFT's as reported in the literature. The second goal is to determine how the language that Approved Supervisors use addresses the issue of agency (responsibility) for violence. The third goal, consistent with research methods incorporating social action, is to increase Approved Supervisors' awareness of the problem of poor therapist response to violence in

families.

To this end, 195 AAMFT approved Clinical Supervisors were invited to complete a brief questionnaire (172 by e-mail, 23 by regular mail). Dillman's (2000) recommendations for e-mail surveys were utilized. 54 participants returned completed surveys. An additional 20 of those invited to participate provided reasons for their non-participation.

Participants were asked to conceptualize and provide interventions for an actual case vignette that described the severe perpetration of violence by a husband and father toward his wife and children, or by a mother and wife toward her husband and children. This male perpetrator version of this vignette has been used previously in studies by Harway, Hansen & Cervantes (1991, 1997) with MFT's. Participants, and non-participants from the sample, will receive a report of the study results by e-mail and will be invited to respond by e-mail, or by participation in an online discussion board.

Data is being evaluated both quantitatively and qualitatively, primarily using critical discourse theory and methods. Preliminary results indicate that Approved Supervisors named the violence more than MFT's did when conceptualizing the case, but appear to have a similarly poor awareness regarding appropriateness of intervention. Additionally, almost all of the participants discussed the perpetration of the violence without assigning agency for it. For example, in responding to the question, "What is going on in this family?" rather than stating "He is physically abusing her and the children," or something similar, participants responded with "marital conflict," or "family violence," or "difficulty with anger issues." Even when the violence was named, as in the use of terms like "domestic violence", the agency of the perpetrator remained obscured.

RETURN TO MAIN MENU

CLINICAL SUPERVISOR SURVEY RESULTS

DISCUSSION

Too often researchers and clinicians live and work in separate spheres. I will be relying strongly on your comments as I discuss the results of this study in the final chapter of my dissertation. You may rest assured, however, that while quotes may be used, I will not identify you by name even if you have chosen to identify yourself on this discussion board.

Please post your thoughts, read the comments of others, and engage with me in what I anticipate will be good discussion:

CLICK TO POST COMMENTS

Of course, if you prefer, you may e-mail your comments to me: adamskath@aol.com. Thank you,

Kathleen M. Adams

RETURN TO MAIN MENU

CLINICAL SUPERVISOR SURVEY RESULTS

POST COMMENTS TO DISCUSSION BOARD

Please use the form below to post your comments, questions, suggestions, etc.

Thank you.

Subject:

Comments:

Submit Reset

* RETURN TO DISCUSSION BOARD

APPENDIX F

STATISTICAL ANALYSIS

Group * Violence Addressed Q1?

Crosstab

Count

		Violence Addressed Q1?		
		Yes	No	Total
Group	Female Perp Vignette	12	7	19
	Male Perp Vignette	32	3	35
Total		44	10	54

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	6.523[b]	1	.011		
Continuity Correction[a]	4.784	1	.029		
Likelihood Ratio	6.266	1	.012		
Fisher's Exact Test				.023	.016
Linear-by-Linear Association	6.402	1	.011		
N of Valid Cases	54				

a. Computed only for a 2x2 table

b. 1 cells (25.0%) have expected count less than 5. The minimum expected count is 3.52.

Group * Violence Addressed Q1? * Gender

Crosstab

Count

Gender			Violence Addressed Q1? Yes	Violence Addressed Q1? No	Total
Female	Group	Female Perp Vignette	5	2	7
		Male Perp Vignette	15	2	17
	Total		20	4	24
Male	Group	Female Perp Vignette	6	5	11
		Male Perp Vignette	13	1	14
	Total		19	6	25
Not provided	Group	Female Perp Vignette	1		1
		Male Perp Vignette	4		4
	Total		5		5

Chi-Square Tests

Gender		Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Female	Pearson Chi-Square	1.008[b]	1	.315		
	Continuity Correction[a]	.161	1	.688		
	Likelihood Ratio	.936	1	.333		
	Fisher's Exact Test				.552	.328
	Linear-by-Linear Association	.966	1	.326		
	N of Valid Cases	24				
Male	Pearson Chi-Square	4.957[c]	1	.026		
	Continuity Correction[a]	3.079	1	.079		
	Likelihood Ratio	5.191	1	.023		
	Fisher's Exact Test				.056	.039
	Linear-by-Linear Association	4.759	1	.029		
	N of Valid Cases	25				
Not provided	Pearson Chi-Square	.[d]				
	N of Valid Cases	5				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 1.17.

c. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 2.64.

d. No statistics are computed because Violence Addressed Q1? is a constant.

Group * Safety addressed? * Gender

Crosstab

Count

Gender			Safety addressed?		Total
			Yes	No	
Female	Group	Female Perp Vignette	5	2	7
		Male Perp Vignette	11	6	17
	Total		16	8	24
Male	Group	Female Perp Vignette	1	10	11
		Male Perp Vignette	7	7	14
	Total		8	17	25
Not provided	Group	Female Perp Vignette		1	1
		Male Perp Vignette	2	2	4
	Total		2	3	5

Chi-Square Tests

Gender		Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Female	Pearson Chi-Square	.101[b]	1	.751		
	Continuity Correction[a]	.000	1	1.000		
	Likelihood Ratio	.102	1	.749		
	Fisher's Exact Test				1.000	.572
	Linear-by-Linear Association	.097	1	.756		
	N of Valid Cases	24				
Male	Pearson Chi-Square	4.738[c]	1	.030		
	Continuity Correction[a]	3.044	1	.081		
	Likelihood Ratio	5.233	1	.022		
	Fisher's Exact Test				.042	.038
	Linear-by-Linear Association	4.548	1	.033		
	N of Valid Cases	25				
Not provided	Pearson Chi-Square	.833[d]	1	.361		
	Continuity Correction[a]	.000	1	1.000		
	Likelihood Ratio	1.185	1	.276		
	Fisher's Exact Test				1.000	.600
	Linear-by-Linear Association	.667	1	.414		
	N of Valid Cases	5				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 2.33.

c. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.52.

d. 4 cells (100.0%) have expected count less than 5. The minimum expected count is .40.

APPENDIX G

POSTTRAUMATIC STRESS DISORDER

Diagnostic Criteria (DSM IV, 1994)

A. The person has been exposed to a traumatic event in which both of the following were present:
   1. the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   2. the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
   1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
   2. recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
   3. acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.
   4. intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
   5. physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   1. efforts to avoid thoughts, feelings, or conversations associated with the trauma
   2. efforts to avoid activities, places, or people that arouse recollections of the trauma
   3. inability to recall an important aspect of the trauma
   4. markedly diminished interest or participation in significant activities
   5. feeling of detachment or estrangement from others
   6. restricted range of affect (e.g., unable to have loving feelings)

7. sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
   1. difficulty falling or staying asleep
   2. irritability or outbursts of anger
   3. difficulty concentrating
   4. hypervigilance
   5. exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

- **Acute:** if duration of symptoms is less than 3 months
- **Chronic:** if duration of symptoms is 3 months or more

Specify if:

- **With Delayed Onset:** if onset of symptoms is at least 6 months after the stressor

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